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ABSTRACT

The Third Annual Report on the Florida Migrant Health Project covered migrant health activities engaged in by 14 counties for the period May 1, 1965, through April 30, 1966. The project was designed to develop a basic statewide program of health services for migrant farm workers and their dependents in Florida. Three of the 12 objectives included working more closely with Project counties in the technical aspects of the migrant health service program as it concerns medical care, improving environmental health by enforcing camp regulations and encouraging growers to provide field sanitation facilities, and solving the migrants' transportation problem. The summary of the county reports for this project period indicated a definite increase in the amount of health services rendered, number of migrants contacted, and activities performed by Project personnel. Also, the number of Anglo workers increased while the number of Negro workers decreased; direct service was extended to 52.7% of the 541 referrals, with 5 categories accounting for 81% of the requests; Negro patients constituted 64.4% of the total number of patients served; and 64.4% of those served were female. The summary further stated that attempts by sanitarians to enforce certain regulations concerning migrant housing and to improve living conditions met with resistance or indifference on the part of growers and public officials and that nursing services, the number of migrant clinics, and the intensity of nutrition education were increased. Related documents are ED 011 217 (1964-65) and ED 013 699 (1966-67). (HBC)

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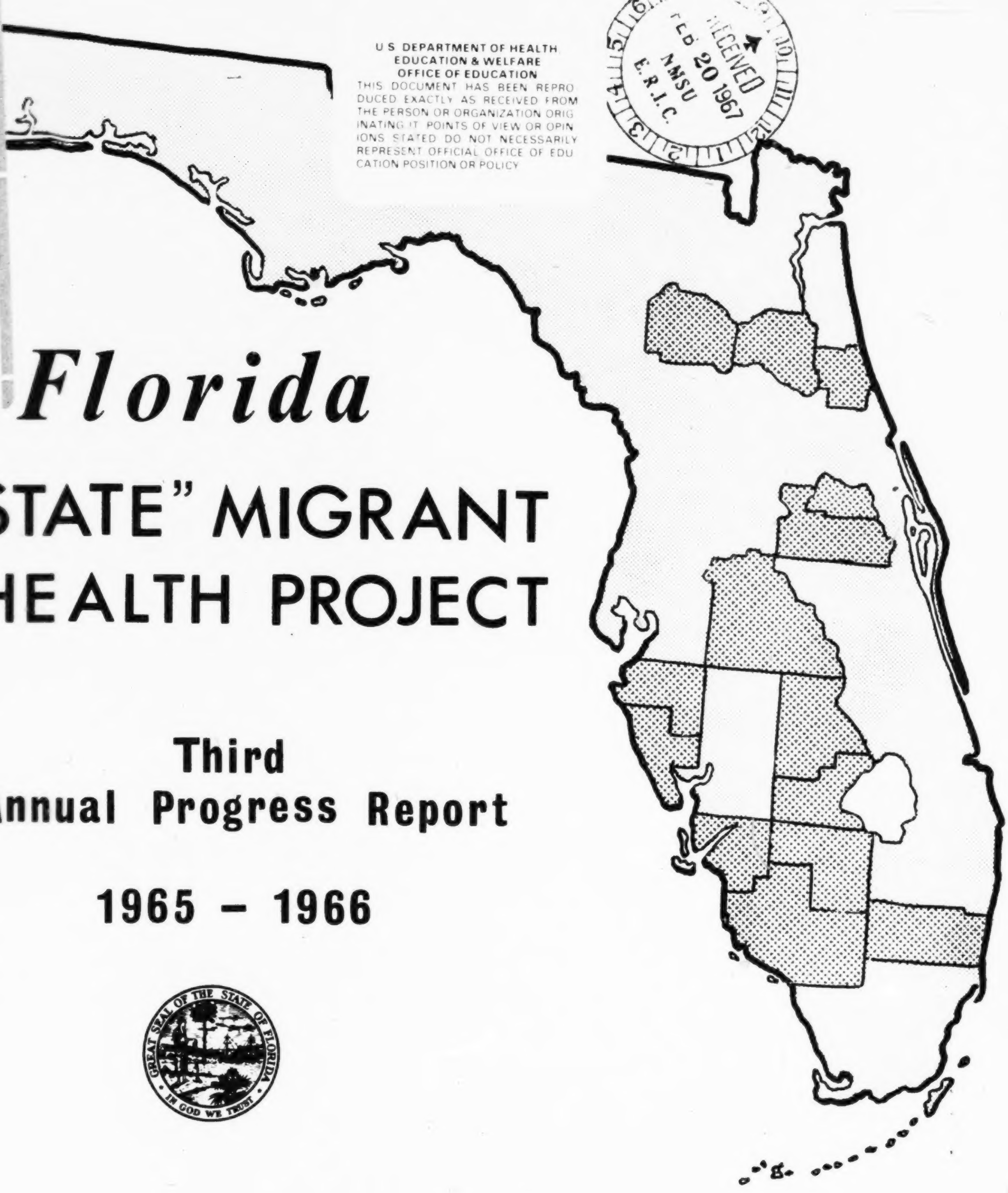

Florida

"STATE" MIGRANT HEALTH PROJECT

Third
Annual Progress Report

1965 – 1966

FLORIDA STATE BOARD OF HEALTH
in cooperation with the
U.S. PUBLIC HEALTH SERVICE

RC 000 780

ED 070536

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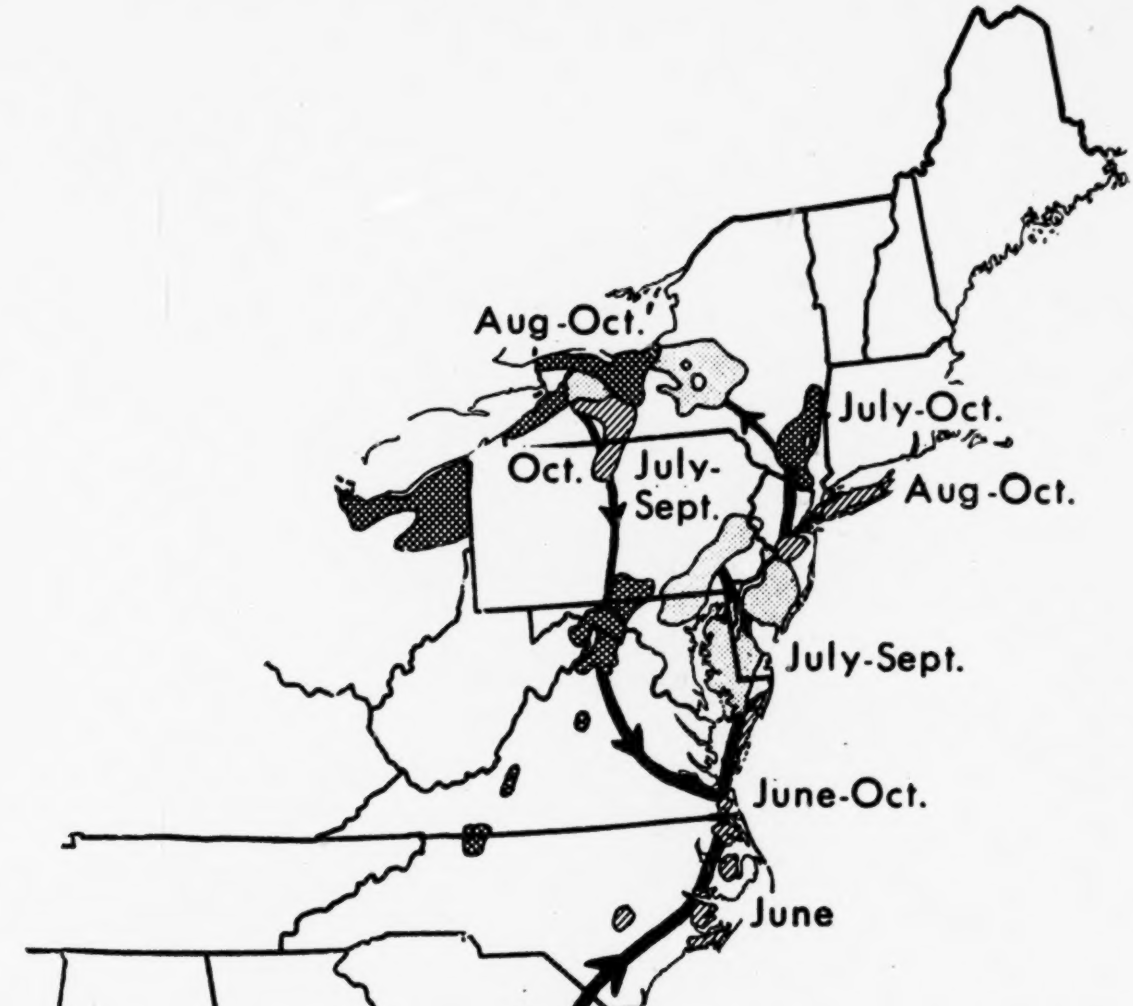
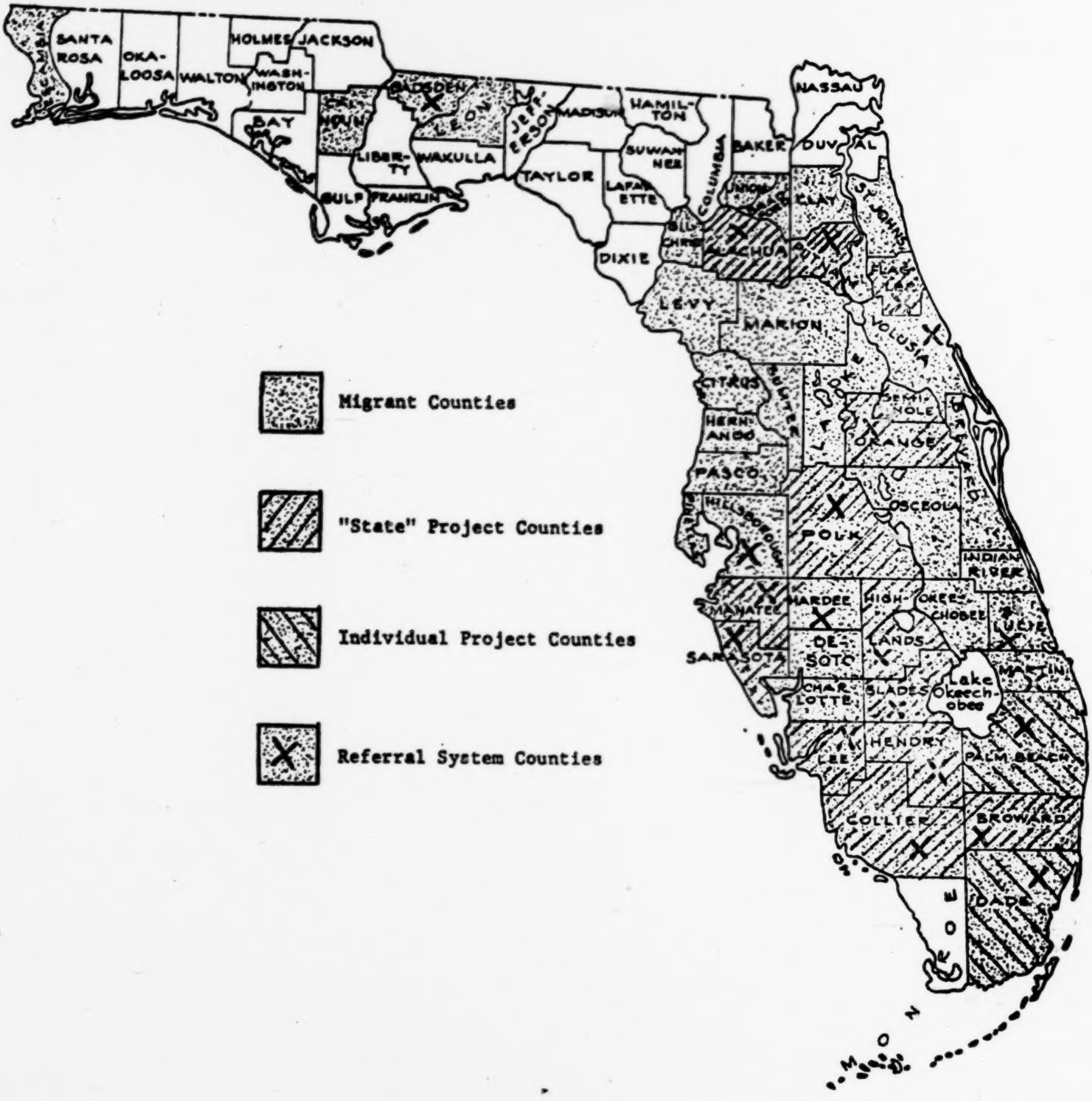

Aug-Oct.
July-Oct.
Oct.
July-Sept.
Aug-Oct.
July-Sept.
June-Oct.
June
May
DATES SHOWN INDICATE HEAVY SEASON OF LABOR DEMAND
Nov.-May

THE ATLANTIC COAST MIGRATORY STREAM.

STATE OF FLORIDA


Migrant Counties
"State" Project Counties
Individual Project Counties
Referral System Counties
SANTA ROSA
OKALOOSA
WALTON
HOLMES
JACKSON
WASHINGTON
BAY
CALHOUN
GADSDEN
LEON
LIBERTY
WAKULLA
GULF
FRANKLIN
JEFFERSON
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SARASOTA
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MARTIN
CHARLOTTE
GLADES
Lake Okeechobee
LEE
HENDRY
PALM BEACH
COLLIER
BROWARD
MONROE
DADE

TABLE OF CONTENTS

PAGES

Preface

Migrant Situation.. 1

Review of Migrant Health Referrals.......................... 3

Project Objectives for 1966................................ 7

Alachua County... 11

Broward County... 25

Collier County... 45

Glades and Hendry Counties................................. 57

Highlands County... 73

Lee County... 81

Manatee County... 99

Orange County.. 121

Polk County.. 131

Putnam and Flagler Counties................................ 149

Sarasota County.. 157

Seminole County.. 173

Report on Nutrition Services............................... 179

Future Plans... 181

Project Objectives for 1967................................ 183

Summary.. 185

FLORIDA STATE BOARD OF HEALTH

ANNUAL PROGRESS REPORT

MIGRANT HEALTH GRANT MG-18C (66)

PREFACE

The following Third Annual Report on the Florida "State" Migrant Health Project is hereby submitted as requested by the United States Public Health Service. This report covers migrant health activities engaged in by 14 participating counties for the period May 1, 1965 through April 30, 1966.

The Florida State Board of Health initially received a grant award from the United States Public Health Service in 1963 to inaugurate a migrant project entitled: "A project to develop a basic statewide program of health services for migrant farm workers and their dependents in Florida." This title was retained for the Second and Third years' operation of the project. The first year's operation might be considered as a "planning" year during which information necessary to implement the following year's action program was gathered. The Project period for the first year extended from September 1, 1963 through August 31, 1964. The first Annual Report covered this twelve (12) month period.

The United States Public Health Service approved Florida's Project Continuation Request and the second or "action" year of the Project started in September of 1964. Ten (10) counties comprised the nucleus of the "State" Project during the first few months of the second year's operation, but a subsequent Project Revision made it possible for three (3) additional counties to participate and to extend the Project period through the calendar year of 1965.

Florida's second Project Continuation Request was tentatively approved (subject to some budget revisions) by the United States Public Health Service in the late fall of 1965. The necessary budget revisions were later submitted and approved in January of 1966 with the current Project year designated as February 1 through December 31, 1966. Fourteen (14) counties are now participating in the Migrant Health Project.

The Project is administered by the Bureau of Maternal and Child Health, Malcolm J. Ford, M.D., Acting Director. The Migrant Health Coordinator is William J. Clarke, Jr.

ANNUAL REPORT

FLORIDA STATE MIGRANT HEALTH PROJECT

Migrant Situation

During the past 1965-66 agricultural season, migrants began returning to Florida around September 15, 1965. At that time there was an estimated agricultural seasonal employment of 23,101 workers of which 22,549 workers were local; 552 were foreign and 1,608 workers were from other areas or other states. About 70% of the early seasonal agricultural employment was concentrated in South Florida vegetable pre-harvest and Central Florida citrus grove care. The small number of foreign workers reported at that time were located in the Lake Okeechobee area and were used to cut sugarcane for replanting.

By November 15, seasonal agricultural employment had increased to 53,270 workers. Central Florida citrus harvest for fresh pack, South Florida vegetable harvest and sugarcane harvest for mill operations were all well underway. Around 9,000 workers from other Florida areas and other states were now employed in seasonal agricultural activities. Agricultural employment reached a peak of 77,800 workers during the middle of February. At the peak, there were 34,468 workers in South Florida vegetable crops and 27,389 in citrus harvest and grove care. During this period, 455 foreign workers were used in citrus harvest for a period of about three (3) weeks and 7,382 foreign workers were used to cut sugarcane for mill operations. Foreign workers were used in citrus to meet a short salvage crisis after the freeze last winter and in sugarcane because no domestic workers were available to cut cane. Although tight labor conditions were reported from time to time, no other serious labor shortages or crop losses were reported. The origin of peak February employment also indicated local workers of 53,633 and 16,300 workers from other areas of Florida and other states. The ethnic composition of the domestic work force was estimated to be Anglo, 17%; Texas-Mexican, 15%; Negro, 58%; Puerto Rican, 10%. The Anglo group of workers increased during the past year due to integrated housing being available in all areas and due to the lack of Negro workers. Other opportunities and programs which were developed last year competed for the use of Negro agricultural seasonal workers.

Due to the late cold weather conditions this spring, Delray, Fort Myers and Bradenton areas reported vegetable harvest periods extending later than usual. The large and increased spring citrus harvest continued very active into June. As compared with the same periods in June a year ago, citrus workers increased about 5,000 workers this year. By June 15th, seasonal agricultural employment had decreased to 49,451. Agricultural workers from other areas in Florida and other states were estimated to be around 3,600 workers at that time.

We only expect significant mechanization development in celery and bean harvest. Lack of an adequate supply of bean pickers has caused a number of growers to pick part of their bean crops with machinery. Partial loss of bean quality and quantity for fresh pack limits the use of mechanization. Celery cutting is expected to be about 60% mechanized this year. Although the number of celery cutters will be decreased this year, the total number of celery workers needed is expected to remain about the same.

Migrant workers begin leaving Florida during May with heavy migration during June after school terms have been completed. Around 40,000 to 45,000 workers and their families are expected to leave Florida this year. First destinations for most migrants after leaving Florida are in the East Coast sections of South Carolina, North Carolina and Virginia. The migrant stream continues up the Eastern Seaboard states after June 15 to Pennsylvania, Maryland, New Jersey and into New York after July 1. The Eastern Seaboard pattern states' agricultural harvest continues active into September and October when many Florida based crews are used in apple harvest in Virginia and New York and in the late fall vegetable harvest in North and South Carolina and Virginia. We also have a significant migrant pattern to the midwestern states of Ohio, Indiana and Michigan. This pattern has grown rapidly during the last five (5) years with a total estimated migrant work force from Florida of approximately 8,500 workers. This pattern begins in July with vegetables and cherries and is completed in September with the Michigan apple harvest.

A REVIEW OF MIGRANT HEALTH SERVICE REFERRALS

Presented here are certain data obtained from review of 541 referral forms used in testing an experimental referral system designed to afford improved health service continuity among migrant farm workers. Only summary information is presented since the data were tabulated by hand: A more comprehensive report awaits machine processing of the data but will be forthcoming.

Referral Sources and Destinations:

Some twenty (20) states were involved in initiating or receiving referrals.

	INITIATED BY		RECEIVED BY	
STATE	NO.	PER CENT	NO.	PER CENT
Total	541	100.0	541	100.0
California	--	--	1	.2
Colorado	--	--	4	.7
Delaware	--	--	2	.4
Florida	297	54.9	281	51.9
Georgia	--	--	7	1.3
Maryland	5	.9	6	1.1
Michigan	--	--	16	3.0
New Jersey	--	--	4	.7
New York	34	6.3	111	20.6
North Carolina	20	3.7	1	.2
Ohio	48	8.9	--	--
Pennsylvania	--	--	6	1.1
South Carolina	16	3.0	44	8.1
Texas	--	--	15	2.8
Virginia	121	22.3	32	5.9
Other	--	--	11	2.0

Service Requests:

The 541 referrals carried 811 requests for service. Five categories of service accounted for 81% of the requests:

(1) Immunization, (2) Health Appraisal, (3) Prenatal Care, (4) Child spacing, (5) Chest X-ray.

The distribution is shown below:

Service Request	Number	Per Cent
Total	811	100.0
Cancer cytology	12	1.5
Chest X-ray	42	5.2
Child spacing	75	9.4
Health appraisal	180	22.2

Immunization	268	33.0
Nutrition	40	4.9
Postpartum care	30	3.7
Prenatal care	94	11.6
Diabetes	7	.8
Intestinal parasites	11	1.4
Rheumatic fever	2	.2
Tuberculosis	32	3.9
Venereal disease	9	1.1
Home nursing care	1	.1
Crippled children	8	1.0

Results of Referrals:

It was found that direct service was provided to 285 (52.7%) of the patients referred. In terms of the service requests, 126 (23.3%) received partial service and 159 (29.4%) received complete service. In 256 (47.3%) of the cases, no service was provided. Public health personnel were unable to locate many patients because of inadequate patient location information. Service was provided in nearly all instances where public health personnel and patients made contact. Sixty (60) or 11.1% of the patients were recorded as having presented themselves for service.

Patient Characteristics:

Negroes accounted for 348 (64.4%) of the group; Spanish, 160 (29.6%); Anglo, 7 (1.3%). Four (.7%) were classed as "other," and 22 (4.0%) were not reported as to ethnic background. There were 190 (35.1%) males and 348 (64.4%) females; 3 (.5%) were not reported. The median age was 15.6 years; the range, under one year to over 65. A third of the group was under six years of age.

Impressions:

In general, the referral forms appeared to be filled out quite acceptably. Incompletions occurred most often with regard to the section headed "Patient Location Information." Approximately one-half of the referrals were initiated without adequate patient location information. This includes 41 (7.6%) on which no patient location information was recorded. Approximately one-third of the referrals lacked either initiation or disposition dates or both. About a third of the referrals were initiated and returned within the same month. Review of this group showed that many were marked "unable to locate" and "no service provided" and had been disposed of before the patients arrived in the area. Some referrals were held for more than a year by the receiving departments, and for the most part, resulted in no service. Most were returned within sixty (60) to ninety (90) days, suggesting that this may be the most productive time span.

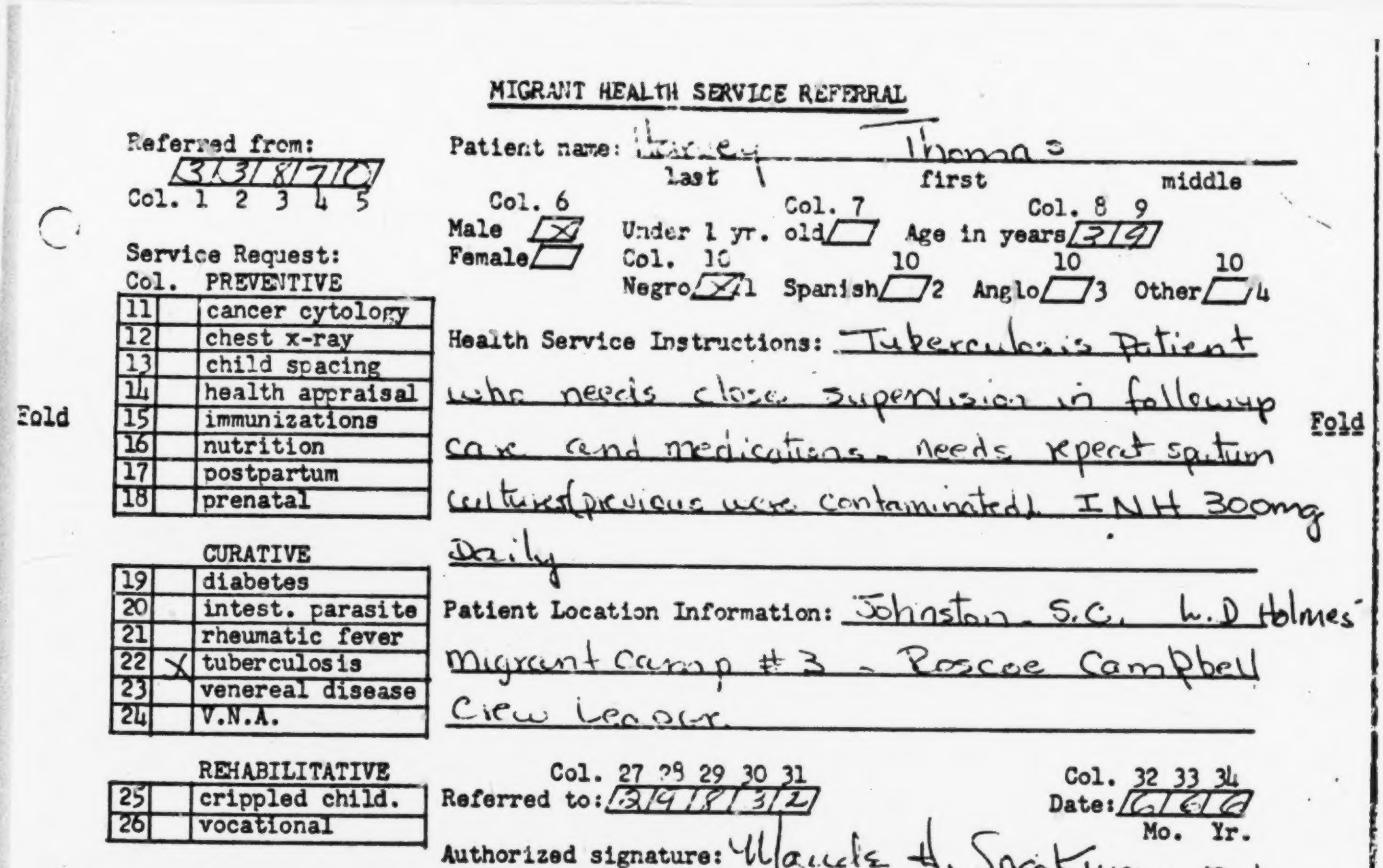
It was noted that, while the majority of referrals carried adequate health service instructions to permit health workers to provide the correct service to the migrant being referred, a sizeable number offered either sketchy information or information which did not clearly indicate why the referral for some specific service was requested. Examples noted were the rather common statement, "Patient seen by doctor and is pregnant." If the box prenatal care is checked, one assumes the patient is pregnant. Information such as expected date of confinement, patient's current health status, etc. will provide necessary data plus stimulation to locate the patient if she has a complication or is near term. In many cases the box health appraisal was checked but no mention was made as to the specific need for this examination. This was most often noted with children, where it is assumed a routine child health evaluation was desired, but some of these infants and children must have had some identifiable health problem which would warrant attention. These should at least be mentioned. Almost, universally when nutrition was checked, there was no remark about the abnormality or problem involved.

Certain weaknesses are clearly evident, but many of them are correctible through further cooperative discussion. Modifications in the design of the health service indexes and the referral form are anticipated and will grow out of further experience.

Though evaluation of the referral system is reserved for a later date, it is felt that the results to date are not without significance. Since 52.7% of the 541 referrals resulted in direct service, perhaps migrants are able to predict their destinations with enough accuracy to allow health service continuity to take place. The involvement of some twenty (20) states in the referral process suggests that the travel patterns of east coast migrants may not be as confined to the Atlantic Seaboard as currently thought.

It is hoped that this report and the more comprehensive one to follow, will reflect some measure of the sincere appreciation we feel for the interest and cooperation evidenced by all the public health personnel who have worked so diligently to make this study and the referral system an effective tool for future planning.

A more recent evaluation of the Migrant Health Service Referral System (than the foregoing review) is currently in progress. In relation to this recent evaluation it is noted that 850 referrals have been returned to the Florida State Board of Health, to date. Among the major problems with the referral system is the disproportionate number carrying insufficient patient location information. It is hoped that this deficiency will be corrected by means of broader in-service education among public health personnel who use the referral mechanism.



MIGRANT HEALTH SERVICE REFERRAL

Referred from: 3 3 8 7 0
Col. 1 2 3 4 5

Patient name: [illegible] Thomas
last first middle

Col. 6 Male ☒ Female ☐
Col. 7 Under 1 yr. old ☐
Col. 8 9 Age in years 3 9
Col. 10 Negro ☒ 1 Spanish ☐ 2 Anglo ☐ 3 Other ☐ 4

Service Request:

Col.		PREVENTIVE
11		cancer cytology
12		chest x-ray
13		child spacing
14		health appraisal
15		immunizations
16		nutrition
17		postpartum
18		prenatal

		CURATIVE
19		diabetes
20		intest. parasite
21		rheumatic fever
22	X	tuberculosis
23		venereal disease
24		V.N.A.

		REHABILITATIVE
25		crippled child.
26		vocational

Health Service Instructions: Tuberculosis Patient who needs close supervision in followup care and medications. needs repeat sputum cultures (previous were contaminated). INH 300mg Daily

Patient Location Information: Johnston S.C. W.D Holmes' Migrant Camp #3 - Roscoe Campbell Crew Leader.

Referred to: 3 9 8 3 2 (Col. 27 28 29 30 31)

Date: 6 6 6 (Col. 32 33 34) Mo. Yr.

Authorized signature: Maude H. Speakman, RN

Fold Fold Fold Fold

PLEASE NOTE: Upon provision of service requested or after 60 days following receipt of referral, please complete REFERRAL EVALUATION (below), fold so that the referral will be sent to FLORIDA STATE BOARD OF HEALTH. The reverse side of this sheet is already addressed. Postage is guaranteed.

REFERRAL EVALUATION

Please mark all items which apply:

Col.		
35	✓	Request for service was provided
		1. Partially
		2. Completely
36		Requested service was not provided
37		Patient sought service requested
38		Patient was sought out by PHP*
39		Unable to locate patient

*Public Health Personnel

:Comments: 3 Sputum tests 6-20-66, 6-21-66-6-22-66 Neg- Given INH. and Pt requested to come in for more if he is still here when they are out

Authorized signature: Gladys W. Crouch PHN

Col. 40 41 42 Date: ☐☐☐ Mo. Yr.

A completed Migrant Health Service Referral Form which originated in Florida and was sent to South Carolina in time to assure further service there. The referral system is designed to provide continuity of health care as migrants move from place to place.

PROJECT OBJECTIVES FOR 1966

(1) To work more closely with Project counties in the technical aspects of the migrant health service program as it concerns medical care.

This objective remains unmet so far this year. We had hoped to employ a public health physician on a part-time basis to consult with directors of those county health departments participating in the Project for the purpose of improving or intensifying the on-going migrant health programs in these counties. To date we have been unable to fill this position on our staff and consequently have been unable to meet this objective.

(2) To continue to provide opportunity for state and local public health officials and others to evaluate the program for migrants and to plan for its improvement.

This objective is rather difficult to evaluate in terms of meeting it or not. Some plans for improving the program were discussed at the December (1965) Migrant Health Conference. The employment of a public health physician (mentioned in the preceding objective) would materially increase the opportunities for evaluating the operations of the various county migrant programs. To date the evaluation and planning have been carried on to a great extent by the Project Coordinator in cooperation with various personnel from participating counties. The Regional Migrant Health Representative of the United States Public Health Service has also assisted in evaluating the program.

Migrant Health Conference planned for the spring in Florida has been postponed until November. We had planned to include evaluation and program planning in the spring conference.

(3) To continue to improve the environmental health aspects of the migrants' existance:
(a) Through stricter enforcement of the Camp Regulations,
(b) Through encouragement of growers to provide field sanitation facilities.

(a) Although there has been some lightening up of enforcement procedures relative to Camps this past season, this pattern has not been project-wide. Sanitarians in some counties have either encountered resistance on the part of growers or lack of cooperation on the part of county officials. Much of this may be attributed to finances, the local power structure and lack of existing sufficient housing facilities. Sanitarians in a few counties made minimal efforts to enforce the regulations. State officials have made plans to take remedial action on the latter situation before the year's end.

(b) As in the preceding paragraph, certain counties have made inroads on this portion of the objective and others have apparently scratched the surface. Field sanitation is one of the most difficult facets of sanitation to sell to the growers.

(4) To develop, utilize and revise when advisable, a uniform system of forms and records for all Project counties.

This objective will be met before the year is out. A record committee has devised a set of forms and records which will shortly be printed up, submitted to all project personnel for inspection and finally discussed and agreed upon during a migrant health meeting tentatively planned for November of this year. This material encompasses activities of various disciplines and project services rendered.

(5) To test a procedure for extending health education to migrants and compiling information on the migrant population through use of liaison workers.

This objective has not been met as the project was not funded to employ migrants or liaison workers which was the original proposal. However, there was some progress made toward meeting the objective in certain counties through the use of VISTA personnel.

(6) To continue to inform the general public and certain groups of the Project's aims and the migrants' problems.

This objective is being substantially met. Project personnel have "planted" articles on migrants and the Project in newspapers, on occassion have been instrumental in using the medium of television to tell the story and have presented talks to various organizations. The September (1965) issue of Florida Health Notes told the story of the migrants and the Project under the title "Better Health for Migrants." Over 2,000 copies of this issue were distributed in Florida and elsewhere.

(7) To involve additional counties in participating in both the Health Service Referral Form System and in the Migrant Project.

This objective has not yet been met in its entirety. The number of Florida counties participating in the Referral System presently remains at twenty-two (22) although we plan to approach a minimum of four (4) additional counties during this project year. It is anticipated that the number of Project counties will increase in the future as two (2) counties have expressed interest in participating in the Project.

(8) To revise the Referral System where necessary and encourage its use both within and outside the State.

The Referral System form is expected to be revised this year as a result of recommendations made by personnel both in Florida and other states who use the form. A meeting is planned for July in Florida at which representatives from many states will discuss the Referral System.

The number of states officially participating in the Referral System (have Health Service Indexes) has increased from five (5) last year to a total of ten (10) at present with a further increase expected.

(9) To offer more comprehensive medical treatment to migrants in Alachua, Broward, Collier, Flagler, Glades, Hendry, Highlands, Hillsborough, Lee, Orange, Polk, Putnam and Seminole Counties:

(a) Through employment of staff physicians to serve as clinicians.
(b) Through referral to private physicians on a fee-for-service per patient basis.
(c) Through employment on a per-clinic session basis (contract) of local physicians to serve as clinicians.

This objective has been met in all but the following counties:
Alachua - No referrals have been made as the season's peak has not yet occurred.
Hillsborough - This county decided not to participate in the Project.
Polk - No migrant clinician has yet been employed.
Seminole - Project staff positions have not all been filled.

We expect all the counties listed in the objective (with the exception of Hillsborough) to attain the objective during this project year.

(10) To offer specified types of dental services (especially emergency) to migrants in Collier, Flagler, Glades, Hendry, Highlands, Hillsborough, Lee, Putnam and Seminole Counties by referral to private dentists on a fee-for-service basis.

This objective has been met by all of the above listed counties with the exception of Hillsborough which decided not to participate in the Project.

(11) To help solve the migrants' problem of transportation:

(a) Through the use of a mobile clinic in Alachua, Broward, Hillsborough and Seminole Counties.
(b) By reimbursement at a specified rate per mile to drivers to transport patients to clinics and offices both in and outside Glades, Hendry and Highlands Counties.

(a) This part of the objective has been met in Broward. It has not been met in the following counties:
Alachua - Decided not to renovate and put into use a bus formerly used as a mobile clinic.
Hillsborough - Decided not to participate in the Project.
Seminole - Tehir request for funds to purchase a mobile clinic was not approved.

(12) To cooperate more closely on the State and local level with any and all groups, agencies and programs involved in working for the betterment of the migrants' lot.

This objective has been met so far, cooperation with various OEO programs has been carried on by both State and County Project personnel and others. Informational programs have been presented by State and County personnel to VISTA training classes. State personnel are helping to develop migrant programs in cooperation with the State Department of Education aimed at helping migrants.

VISTA workers have been assisting the Project in various ways as mentioned in some of the following county reports. The complete list of agencies and groups involved in working with migrants with whom we have cooperated would be too lengthy to mention here.

ALACHUA COUNTY HEALTH DEPARTMENT

Edward G. Byrne, M.D., Director

Area of County: 892 square miles

Resident Population: 86,500

Number of Migrants: 1,500

Migrant Project Staff: 1 Public Health Nurse
1 Senior Sanitarian

DOMESTIC AGRICULTRUAL MIGRANT SITUATION IN PROJECT AREA

ALACHUA COUNTY

The Migrant population served reached a major peak in April through mid June. This peak was comprised of approximately 850 migrant workers plus dependents for an estimated total of more than 1500. This is about half of what was expected. Fall crops bring a major peak expectation of about 500 migrant laborers from mid October until mid November. There is an estimated expected total in excess of 800 migrants during the Fall months.

The ethnic background is judged to be as follows: Negroes 75%, Texas Mexicans 20%, and Caucasians 5%. This is an estimated percentage increase of 100% of Texas Mexicans and a percentage decrease of 28% in Negroes, with Caucasians remaining constant (see Attachment "A") as compared with last year.

Migrants started to arrive about March 1, 1966 and due to the poor crops and bad weather conditions, many of them left early or are in the process of leaving now, June 1, 1966.

Most of the migrants come to Alachua County from Dade, St. Lucie, Sarasota, Broward and Palm Beach Counties, Florida. From Alachua County many of the workers will go to Virginia, North Carolina, Maryland, Delaware, (New Jersey), New York, and South Florida, with a few going to Pennsylvania.

The number of migrant farm workers who consider Alachua County their permanent home is so small that at present it is insignificant; although there seems to be a trend starting in the local labor group to join the stream.

The number and location of camps and other major concentration of migrant housing is found under sanitation services.

Due to crop failures, weather and the shortage of labor when needed, it is uncertain at this time what the labor situation in this county will be this coming year. Mechanization of crop harvesting, except in the harvesting of potatoes, has had no appreciable increase this year and the status quo in this facet of agriculture is expected to prevail next year. If it were not for the ruinous weather conditions, the labor shortage would have been critical in this area due to the fact that half to less-than-half of the normal number of migrants appeared in the area.

FAMILY HEALTH SERVICE CLINICS

During the past twelve months, two types of clinics have been held in the town of Alachua (the center of the migrant area), nursing clinics and general medical clinics. Nursing clinics are staffed by two staff nurses, one paid worker and two volunteers. Medical clinic staffs are the same, with the addition of one physician. All nursing clinics run from 10:00 A.M. to 4:00 P.M., while the medical clinics run only from 9:00 A. M. until noon.

During the year, there were 24 medical clinics held; total attendance of 512 persons and 50 nursing clinics with a total attendance of 2681. Five spot clinics were held in the area of two migrant camps with a total attendance of approximately 125 persons. The mobile x-ray unit was used in seven migrant camp locations. A total of 433 x-rays were taken. Heavy rains during the peak of the season caused a lower migrant population than was estimated. During the year, some of the migrants were seen by other Health Department staff - physical therapist, mental health professional, nutrition consultant, or other consultants - made available through the staff structure.

Approximately two-thirds of the patients seen in the clinics were in the adult age range and the remainder were children. The number of aged was very small. The vast bulk of the adults were female.

The exact number of these patients who were migrants was not recorded. During peak seasons approximately 25% of the total population of the area are migrants and apparently received their proportion of services.

A small number of referrals were made to other agencies, such as dental clinic, private physicians, University of Florida Hospital and Alachua General Hospital. Some of the migrants sought aid, on their own initiative, in time of emergencies. These emergencies included injuries, food poisoning and acute illness, which were treated at the emergency room of the local hospitals. It was found that very few individual migrants would take the responsibility for carrying out referrals given them unless the assistance of crew leaders or farmers was obtained.

During the year health education was extended through meetings with the growers, personal contacts with crew leaders and individual migrants. Individual counselling was given in the matters of venereal diseases, tuberculosis, maternity care, nutrition, communicable diseases and immunization needs of all adults and children. A special effort was made, through individual counselling, to help the migrant to understand or evaluate his own health needs and to accept the responsibility for finding ways of meeting these needs.

Because of the scattered locations of the migrant camps, it was found by the nursing staff that the best way to work with the migrants was to make personal contacts with individual migrants, farmers and crew leaders. A meeting of the Alachua County Vegetable Growers Association, County Agent, District Farm Labor Representative, sanitarian and nurses held prior to the scheduling of mobile x-ray units in the migrant areas proved helpful in stimulating interest and obtaining the cooperation of the growers.

During the year, approximately 20 patients were given health records with instructions to see a doctor or contact a Health Department some place else in the migrant stream. Referrals were also made out and forwarded to the next anticipated workstop and to localities to which the migrants usually return. None of the migrants presented a health card to us. We received five migrant referrals from other counties. One referral was on an eight year old child from the LaBelle (Florida) area who had a positive reaction to a PPD test but had left the area before a chest x-ray could be made. A chest x-ray was made here and the child was placed on INAH. A five months supply of INAH was given to the patient and instructions given to report to us in October, 1966, when she expects to return to this area. Two referrals were on adult tuberculosis suspects. We were unable to locate these migrants. Another referral was on a new mother and infant. The mother and baby were located and necessary follow-up was done. The fifth referral was on a woman who was on a child-spacing product. We were unable to locate her. As a result of the chest x-rays made by the mobile x-ray units in migrant areas, personal contacts with the migrants were made on all reports of pathological findings such as enlarged hearts, suspicious tuberculosis and emphysema. One patient was hospitalized in W. T. Edwards Tuberculosis in Tallahassee for diagnosis.

NURSING SERVICES IN CAMPS OR OTHER PLACES WHERE MIGRANTS LIVE IN PROJECT AREAS.

During the past year there have been two full-time staff nurses working in the general migrant labor area, as well as two part-time nurses. There were three part-time paid employees, and three volunteer employees for the clinic operations. The project nurse estimates that there are eight to ten population concentrations that have received service. The major deficiencies noted in these areas were garbage disposal and sewage disposal.

Approximately 1200 field visits were made in the project area during the past year. Twenty per cent of these visits were to migrant laborer families. Approximately 60% of the migrants visited were given some type of referral for additional services such as health department clinics, private M.D.'s, Pediatric Charity clinic and Welfare Department. Approximately one-half of those given referrals carried through and completed referrals. Lack of transportation, working hours and apathy were the main reasons given for not completing referrals.

Major hindrances to proper health services seem to be due to lack of camp organization, centralized health facilities and apathy on the part of individual migrants to assume responsibility for determining their own health needs and problems. The most effective approach to the migrants seems to be through personal contact by nurse and sanitarian with growers and crew leaders.

MIGRANT PROJECT

Alachua County, Florida

February - March, 1966

1. PROJECT OBJECTIVES

A. "Improving Environmental Health Factors Survey" was done by the Environmental Health Staff to identify various housing areas used by migrants in the area.

An organized committee was developed involving the Employment Agency and the County Agricultural Agent, who are to work with the Vegetable Growers Association in the County toward meeting the housing and sanitation needs of the migrant laborers. A series of meetings of this group has been set up.

B. Development uniform record system:

Samples of proposed records have been received from the State Board of Health and are under intensive study by Alachua County and other participating counties in the migrant project as to revision and the records suitability.

C. Emergency Service for Migrant Farm Laborers:

Arrangements have been made with the Alachua General Hospital for receipt of these patients, and service provided together with payment to the hospital for services rendered (not to include physician services).

D. Emergency Dental Services:

Though this is not a part of the project application, tentative plans have been made whereby emergency dental services can be made available to migrant laborers in Alachua County, through referrals by the public health nurse.

"SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK FACILITIES"

1. "STAFF"

List of personnel and per cent of time spent on project work:

1 Health Officer (Director)	3%
1 Sanitation Director	3%
1 Sanitation Supervisor	3%
1 Sanitarian	100%
1 Clerk Typist	1%
1 Clerical Personnel	2%

One full-time sanitarian has been approved for this project but because of the unrealized scope and intensity of migrant situations, the other personnel have been required to devote time to the project. (Map Attached - Exhibit "B").

The map shows the location of camps. This map does not give the complete picture of the number of camps in this county. It seems at this point that a great many more housing units exist than had been previously recognized.

Laws, regulations or other criteria for evaluating camps are included in the provisions of the Florida Sanitary Code. (Copy attached - Exhibit "C", see NOTE page 16.)

MIGRANT LABOR CAMP LEGEND

CAMP NO.	MIGRANT LABOR CAMP NAME
1.	Island Grove Growers and Shoppers
2.	Beverly Hills Plantation
3.	N. T. Thomas
4.	Roy Cellon
5.	Gays Labor Camp
6.	Worth Harris
7.	Mo - Bo Produce Company
8.	Lacy Bokes
9.	Mo - Bo Produce Company
10.	Joe Imler
11.	Wilburn Hague

(Camp numbers relate to camp locations on Exhibit "B")

A total of thirty-three (33) camp visits have been made to the eleven (11) recognized, but substandard camps. To date there are not any legally permitted camps, but as they meet minimum standards they will be permitted.

The chief methods to be used in obtaining correction of camp defects are:

(1) Discussions and conferences with the camp operators
(2) Health education to those living in and/or operating a camp
(3) Discussions and conferences with the camp owner
(4) Frequent and complete inspections of camps and their facilities
(5) Enforcement of standards

Since there are no comparative experiences or data from previous years for this locale the above system of methods is to be used until conditions and times warrant a change. There will not be, at this time, any rigid or hard-and-fast patterns as flexibility in approach is needed at present.

Observations have brought to light the fact that almost any type of structure is being used as housing by migrants at the peak of the season.

The major location for migrant housing is the Northwest and Western areas of the county plus the low income areas in the City of Gainesville.

The Sanitary Code does not regulate single and duplex family residences or rooming houses. Water supply, nuisance control, garbage and rubbish disposal, sewage disposal and food service are regulated by the Florida State Sanitary Code. (Copy attached - Exhibits "E", "F", "G", "H", "I" and "J") (NOTE: Copies of these exhibits are extremely limited.)

From February until June 1, 1966 there were 182 visits made to 82 places other than camp locations, including 21 housing units. Because of delay in salary appropriations, it has not been possible to inspect the housing units to determine if they meet minimum standards.

Thirty-five (35) separate field locations have been visited this season. This is approximately 25% of all fields using migrants. The total number of field visits concerned in relation to field sanitation is seventy-one.

All fields visited used portable water coolers for their drinking water. These coolers are filled at the source of ice purchase, or at the camp. Bacteriological analyses have not been run on the camp water supplies but will be performed as soon as possible. Hand washing facilities are not provided in the fields.

Only one grower provided sanitary facilities of any type in the fields. These facilities did not meet minimum standards and consisted of one privy.

Evaluation of field sanitation is determined by the regulations set forth in the Florida State Sanitary Code.

Education of growers, migrants, camp managers, group leaders and other persons has been and will continue to be a very important part of this project. Thus far excellent results have been obtained for the efforts expended.

COUNSELLING ON SPECIFIC PROBLEMS BY TYPE OF PROBLEM

Personnel Hygiene	73
Water Supply	43
Sewage Disposal	46
Campsite	25
Plumbing	38
Sanitary Facilities	53
Insect and Rodent Control	67
Structure	78
Food Service	34
Garbage and Trash	61
Fire Protections	21
Construction	42

Heating and Electricity Use	48
General	146

PERSONAL HYGIENE - Cleanliness and Maintenance of personal body.

Example: Migrant is found to be ill. The sanitarian points out to him the importance of following the doctor's advice and taking his prescribed medicine.

WATER SUPPLY - Water supplies must meet the requirements of the Sanitary Code.

Example: Well site is checked by the sanitarian and is found to be unprotected. Explanation is given to the camp manager and grower for the need of protecting the well and how to protect it. Site is investigated, as needed, for compliance with the requirements.

SEWAGE DISPOSAL - New sewage disposal systems need the approval of the Alachua County Health Department. Completed and incompleted systems are inspected for compliance.

Example: New septic tank installation for restrooms. System must be of approved type, size and installed according to code. When the system meets the approval of the Health Department, it is then allowed to be used.

PLUMBING - Must be in accordance with the Code. Misuse and inadequate maintenance of the fixtures creates a large number of problems.

Example: Toilet is torn from the mounting. A conference is held between the camp manager, owner and sanitarian so that the repair and maintenance may be facilitated.

INSECT & RODENT CONTROL - Due to location, personal habits and type of structure there is usually a high concentration of insects and rodents.

Example: Information and directions are given to the manager about control of fly breeding and rodent control by the sanitarian.

STRUCTURE - Importance of good maintenance of housing structures is conveyed to growers, operators, crew leaders and migrants.

Example: Partition is destroyed between sleeping rooms. It is to be repaired because, as the sanitarian points out, this can be a source of unrest among the crew due to lack of privacy and protection of their belongings and themselves.

FOOD SERVICE - This involves the whole scope of both public and private food service.

Example: A crew leader is operating a kitchen for profit. The basic requirements of food storage are pointed out to the leader.

GARBAGE & TRASH - Storage and disposal seem to be a constant problem.

Example: Camp does not have any storage facilities. Migrants are disposing of their garbage and trash wherever they wish. Instructions are given for the procurement of garbage and trash cans, with lids, to be used as containers until it can be disposed of in a sanitary manner.

FIRE PROTECTION - Most of the camps are either given fire protection by the Florida Forestry Service or by Volunteer Fire Departments.

Example: A conference is held with the crew leader and camp manager about fire control and protection.

CONSTRUCTION - New housing facilities or remodeling of the existing ones are needed. The need has to be recognized by the growers and money made available.

Example: A grower is experiencing difficulty in obtaining labor because of the lack of housing or facilities. A conference is held between the grower and sanitarian. The sanitarian explains what he thinks the grower's problem is - "Labor wants decent housing" - Types of housing and facilities are discussed with an outcome that satisfactory housing will be constructed.

HEATING & ELECTRICITY USE - Little knowledge is exhibited of heating units and electricy by the migrants. The feeling is that as long as they perform, they are satisfactory.

Example: A leaking fuel tank on a kerosene heater is found by the sanitarian. It is pointed out to the users and the crew leader that there is a good chance of both fire and explosion because of the leak.

GENERAL - Areas of counselling not previously mentioned.

Example #1

A migrant is found by x-ray to be a tuberculosis suspect and the county store keeper whom he deals with refuses to serve him because of it. The sanitarian discusses the situation with the store keeper, assuring him that there is no danger to him or his family. An explanation to the store keeper of what a x-ray report of suspicion of tuberculosis means and how it is handled by the Health Department results in clearing confusion and resuming trade to the migrant.

Example #2

A complaint is received from migrant crew members against a fellow member's hog pen. Upon investigation the sanitarian found a small pen holding a sow and pigs. The odor and flies from the pen presented an unbearable condition.

Showing and explaining the situation to the migrant owner resulted in the removing of the hogs to a more isolated area which is being maintained satisfactorily.

Example #3

There is a misunderstanding by a grower about the purpose of a special migrant x-ray project performed in this area. The grower and sanitarian discussed the purpose of the project and the grower was assured the project would be beneficial to him. This conference resulted in excellent cooperation from the grower.

"TYPES OF INDIVIDUALS AND GROUPS WITH WHOM WORKING RELATIONSHIPS WERE ESTABLISHED AND PURPOSES OF RELATIONSHIP."

Alachua County Building and Zoning Department - Cooperation, coordination and development of programs dealing with zoning, sewage, structural standards, etc.

Alachua County Vegetable Growers Association - Development of housing and sanitation programs for growers and migrants.

Florida Employment Agency - Coordination and improvement of a cooperative program.

Alachua County Agricultural Agent - Cooperation and improvement of housing and sanitation program.

Alachua County TB Association - Coordination and performance of migrant x-ray project.

Provisions made for orientation and in-service training of staff:

General staff meetings are held once a week to discuss general problems and activity.

Conferences are held among migrant project staff when needed and at least once a week. Policy problems, activities and in-service training are discussed during these conferences.

Staff members are encouraged to participate in home study courses plus the use of available resources, materials and other literature in the Health Department and the University of Florida's libraries.

PROBLEMS WHICH PREVENT OR HINDER GROWERS IN MAKING IMPROVEMENTS AND MAINTAINING THEM

The major problems in this area seem to be mostly psychological and economical. Due to limited time spent on this project because of the time element involved in appropriations, it is not known what the total scope of the problems are.

For several years the number of growers has decreased annually. Though the remaining growers have maintained their own acerage, the total acreage has decreased due to the lessoning of the growers' numbers. Age, death, and economics are partly responsible for the decrease. The bad crops this year may cause a further decline in number of growers and amount of acreage planted.

Growers are hesitant to spend money for improvement and maintenance of facilities when they do not know if they are even going to stay in business. If they do stay in business many will not know on what scale. This makes commitments difficult to obtain.

Even though most growers are bitter toward many government rules, regulations, controls and agencies this project has enjoyed an excellent cooperative and helpful spirit from them.

Project staff have used an educational approach for obtaining compliance with requirements and standards, but enforcement will be used if necessary.

The major problem of the grower seems to be economics.

PROBLEMS PREVENTING OR HINDERING THE PROPER USE AND MAINTENANCE OF HOUSING AND FACILITIES BY MIGRANTS

The most apparent problems are psychdogical, social and economic and educational level of the people involved. These problems will take years to solve and then may correct themselves only through future generations.

The lack of housing and facilities which meet standards is also a major problem for them to cope with. It is impossible for a migrant to use or maintain something that does not exist or is in such ill repair that it is unusable.

Besides improving the physical conditions of labor housing and facilities, labor must be able to adjust to his new environment. Elevation of the psychological, social, economic and educational level of the migrant is taking place but the progress is slow.

"GENERAL APPRAISAL OF RESULTS OF SANITATION SERVICE"

"Migrants understanding and acceptance of responsibilities for improvement of their own practices in the use of housing and field facilities."

Responsibility is something the present day migrant, in this locale, does not want to assume.

However, this attitude is changing, as the hog complaint previously mentioned proves.

Of the fields visited, only one grower provided toilet facilities, but this condition is expected rather than the reverse by the migrants. Talking with several of them pointed out this fact.

"CAMP AND OTHER OWNERS" ACCEPTANCE OF RESPONSIBILITY FOR PROVIDING AND MAINTAINING FACILITIES IN AN ACCEPTABLE WAY"

Owners are aware of what their responsibilities are for providing and maintaining facilities for migrants. This was brought out many times by the owners during the course of conversation but most of them consider this an evil that has to be borne to obtain the labor they need.

"DISEASE CONDITIONS ATTRIBUTABLE TO POOR HOUSING AND SANITATION"

The sanitarian coordinated and helped conduct a special migrant x-ray project which was performed during May 19, 1966. There were 433 x-rays made, seven (7) suspicious of tuberculosis cases and five (5) pathology cases were found. This high incidence is being investigated to determine what conditions might contribute to this situation.

Disease stemming from poor housing and sanitation is difficult, at present, to report in a statistical manner as so many cases are untreated, unreported and hidden.

"GENERAL APPRAISAL OF ADEQUACY OF SERVICES"

Fair appraisal of the adequacy of services rendered is not feasible at this time because of the short duration of the project period experienced. Only the future will unfold the true adequacy of the services the project staff are able to render.

The Migrant Project has enjoyed, to date, success in all fields of endeavor, as the report indicates. Staff members all agree that as the program evolves, it will be more difficult to procure this degree of success.

"COMMUNITY UNDERSTANDING OF THE SITUATION, RELATIONSHIPS AND ATTITUDES"

Here again it is not possible to give a comprehensive evaluation due to the limited length of time the project has been in effect. As time goes on, a clearer picture of the true condition can be presented.

It seems at the moment that the people have a fairly good understanding of the migrant situation but their relationship is one of nonassociation. Their attitude is one of accepting the fact that the migrant is needed to gather the crops but they do not belong. If a migrant settles down in the area, he is accepted in the community for what he is and what he makes of himself.

"GROWER - MIGRANT RELATIONSHIPS, WILLINGNESS OF MIGRANTS TO STAY THROUGHOUT THE SEASON, ETC."

The relationship between the grower and the migrant is fairly good. There are migrants who have been working for the same grower for as long as 18 years. This season there was a large turnover because of the poor crop year, thus causing a shortage of work, but this turnover on a whole was not due to a poor working relationship.

"SPECIFIC INFORMATION AND SUGGESTIONS BASED ON THE SEASONS' EXPERIENCE"

Meetings with grower associations, such as the Alachua County Vegetable Growers Association, have been and will continue to be an excellent and effective means of coordinating, planning and facilitating grower and migrant programs.

The system of recording functions performed needs to be revamped. This seems to be true at least in this locality at present and perhaps in other projects within the State. A new, more effective system is being worked on by the project staff for their use.

As the project is in its infancy, it is expected that more meaningful and helpful information and suggestions will be established as maturity comes. New ideas are being sought, found and put into use every day.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

Several migrants were discovered to have skills, training and experience which were not realized until intensification of the project developed. Brick masons, carpenters, plumbers, nurses aides, etc. are in the stream but the staff is finding it difficult to develop the potentials of these people. This is attributable to the fact that the migrant himself does not want to accept responsibility.

Potentials were discovered by the staff through the development of close personal working relationships with migrants, crew leaders, camp managers and growers. (Observation of work performance showed that some migrants are highly skilled.) Cultivation of the migrant to accept responsibility is one of the keys for the advancement of the migrant.

Crew leaders, field walkers and the elderly were the most cooperative among the migrant groups. Past experience, intelligence and the willingness to accept responsibility are attributes possessed by the above to varying degrees which helped them to be particularly cooperative.

The relationship developed by the project staff, especially the sanitarians with the migrant groups, is one of the main reasons for the involvement of these groups with the project. Methods used to involve these groups and others to produce more effective efforts and achievements are explained in foregoing sections of this report.

Contributions to the project do not lend themselves to statistical tabulation. For example: How do you tabulate trust and faith by the migrants in the staff members?

Individuals and groups other than migrants have been especially cooperative and helpful with this particular project. It is hoped at this time that new groups can be motivated to join the others in attaining the goals of this project. All groups contacted so far have been most responsive.

There have not been any particular groups or individuals obstructive to the project. The problems involved are brought out in detail under Sanitation Services related to Migrant Housing and Work Localities.

The project is experiencing a language problem with the Spanish-speaking peoples in the stream. So far the staff has been able to cope with this problem through the use of biligual migrants and employment of a sanitarian who has a fair working knowlege of Spanish. It is fortunate to have personnel who know and understand the mores and folkways of the people with whom he deals.

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Obtaining funds for a sanitarian and data recording have been the biggest administrative obstacles in carrying out project objectives this year. These obstacles are being overcome. A sanitarian has been employed with Grant Funds especially for the migrant project. A Migrant Labor Records Committee has submitted, at the State level, their recommendations for the improvement of records and record keeping methods.

SOURCES OF SUPPORT OTHER THAN THE FEDERAL MIGRANT GRANT THIS YEAR

The project obtained financial support from the following contributors:

Welfare Department (Burials)	$ 250.00
Alachua Hospital (Unpaid Bills)	3,900.00
Dentists (Unpaid Bills & Donated)	2,000.00
Health Department Personnel (Time & Travel)	4,600.00
Health Department (Supplies, Migrant Transportation, etc.)	350.00

Other sources of support, excluding direct financial contributions, are listed below:

- Alachua County Building and Zoning Department
- Florida Employment Agency
- Alachua County Agricultural Agent
- Migrant Health Representative (United States Public Health Service) Out of the Atlanta office
- State Migrant Health Coordinator - Out of the Jacksonville office

The new support that the project has enjoyed is due to the concentrated effort of the environmental health staff. In the past, prior to sanitation personnel involvement, only the Florida Employment Agency and the Migrant Health Coordinator and Representative lent this project support. Increased support from new and the above sources are in the future picture.

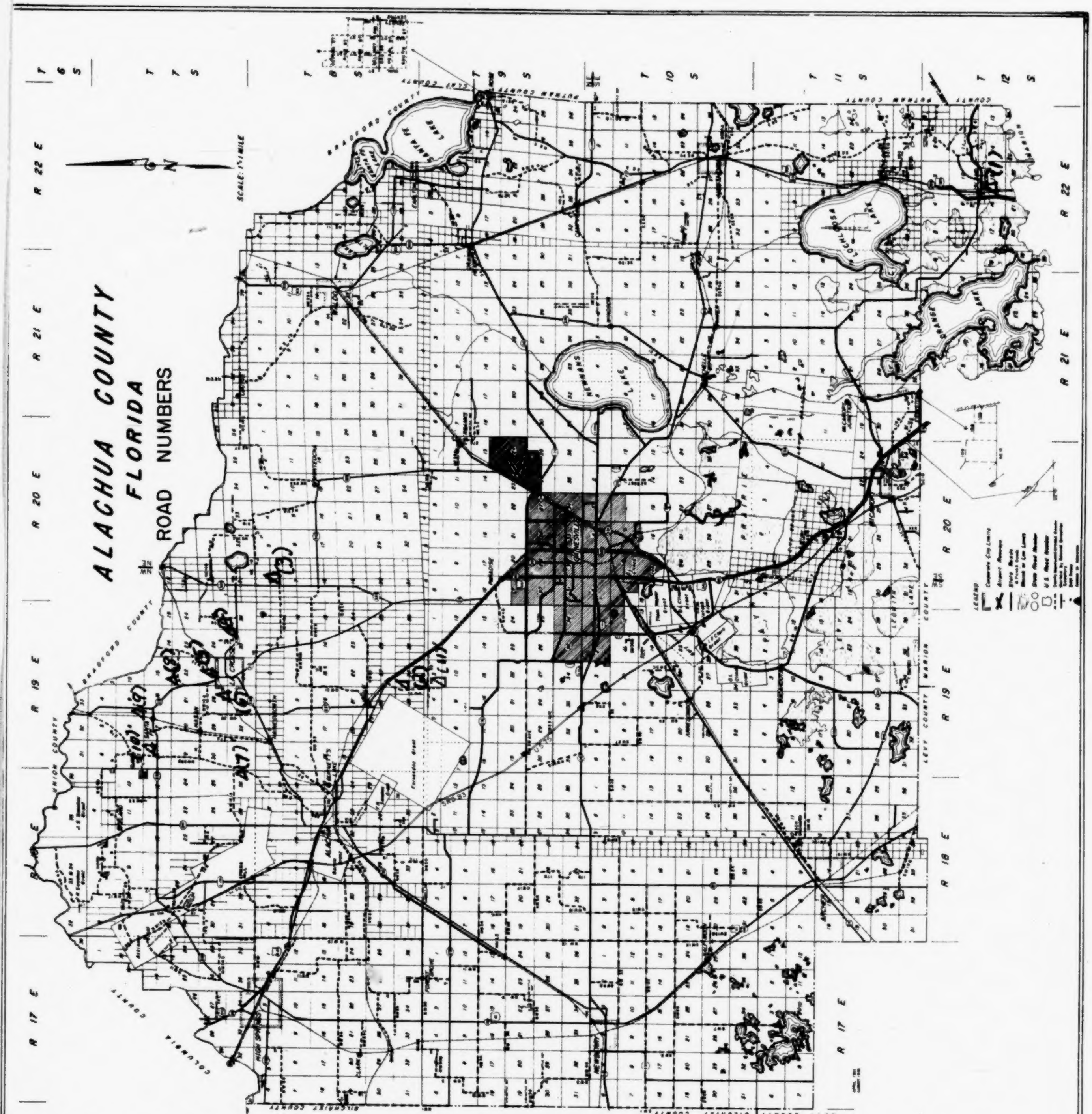
Great improvement in the attitudes and willingness to support and/or participate in the migrant project has been displayed this season among all people involved. Continued work with these groups and success with them will determine the effectiveness of the program to a great extent.

The Migrant Labor Records Committee has submitted detailed information for the improvement of data collection and reporting. This office concurs with their findings and recommendations.

EXHIBIT "A"

ETHNIC BACKGROUND

	Per Cent 1965 - 1966	Percentage Change Since 1964-1965
Negro	75	-28
Texas-Mexican	20	100
Caucasians	5	Constant


ALACHUA COUNTY
FLORIDA
ROAD NUMBERS
N
NEWNANS LAKE
LOCHLOOSA LAKE
ORANGE LAKE
SANTA FE LAKE
BRADFORD COUNTY
PUTNAM COUNTY
MARION COUNTY
LEVY COUNTY
GILCHRIST COUNTY
COLUMBIA COUNTY
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LEGEND

EXHIBIT B

CHAPTER 59 - 476

EXHIBIT "D"

HOUSE BILL NO. 269

AN ACT relating to the State Board of Health; defining migrant labor camps; requiring that such camps be licensed; providing for the application, issuance and revocation of license; authorizing the board to issue regulations; providing for right of entry; and setting an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF FLORIDA:

Section 1. Definitions. - The following words and phrases shall mean:

(1) Migrant labor camp. One (1) or more buildings or structures, tents, trailers, or vehicles, together with the land appertaining thereto, established, operated or used as living quarters for fifteen (15) or more seasonal, temporary or migrant workers whether or not rent is paid or reserved in connection with the use or occupancy of such premises, provided however, this definition shall not apply to forestry or tobacco farm operation.

(2) Board: The State Board of Health.

Section 2. License required for establishment, maintenance or operation of migrant labor camp. - No person shall establish, maintain or operate any migrant labor camp in this state without first obtaining a license therefor from the board and unless such lincese is posted and kept posted in the camp to which it applies at all times during maintenance or operation of the camp.

Section 3. Application for license. - Application for license to establish, operate or maintain a migrant labor camp shall be made to the board in writing and on a form and under regulations prescribed by the board. The application shall state the location of the existing or proposed migrant labor camp, the approximate number of persons to be accommodated, the probable duration of use and any other information the board may require.

Section 4. Issuance of license. - If the State Health Officer is satisfied, after causing an inspection to be made, that the camp meets the minimum standards of construction, sanitation, equipment and operation required by regulations issued under Section 6 of the act, he shall issue in the name of the board the necessary license in writing on a form to be prescribed by the board. The license, unless sooner revoked, shall expire on June 30 next after the date of issuance unless renewed, and it shall not be transferrable. All applications for renewal shall be filed with the State Health Officer thirty (30) days prior to its expiration on form blanks furnished by the board.

Section 5. Revocation of license. - The State Health Officer may revoke a license authorizing the operation of a migrant labor camp if he finds the holder has failed to comply with any provision of this act or of any regulation or order issued hereunder.

Section 6. Authority to issue regulations. - The board shall make, promulgate and repeal such rules and regulations as it may determine to be necessary to protect the health and safety of persons living in migrant labor camps, prescribing standards for living quarters at such camps, including provisions relating to construction of camps, sanitary conditions, light, air, safety, protection from fire hazards, equipment, maintenance and operation of the camp and such other matters as it may determine to be appropriate or necessary for the protection of the life and health of occupants. Regulations adopted hereunder shall be a part of the Sanitary Code of Florida created by 381.031(1) (g) 12. and may be enforced in the manner provided in 381.031(4), and violations thereof shall be subject to the penalties provided in 381.411.

Section 7. Right of entry. - The board and/or its inspectors may enter and inspect migrant labor camps at reasonable hours and investigate such facts, conditions and practices or matters as may be necessary or appropriate to determine whether any person has violated any provisions of this chapter or rules and regulations of the board pertaining hereto are being violated. The board may from time to time at its discretion publish the reports of such inspections in its monthly bulletin.

Section 8. Effective date. - This act shall take effect immediately upon its becoming law.

Approved by the Governor, June 19, 1959.

Filed in Office Secretary of State, June 20, 1959.

BROWARD COUNTY HEALTH DEPARTMENT

Paul W. Hughes, M.D., Director

Area of County: 1,218 square miles

Resident Population: 400,000

Number of Migrants: 5,000

Migrant Project Staff:
- 2 Public Health Nurses
- 1 Sanitarian
- 1 Clerk-Typist
- 1 Public Health Nurse Supervisor I

BROWARD COUNTY MIGRANT HEALTH PROJECT

ANNUAL PROGRESS REPORT

April 30, 1965 - April 30, 1966

INTRODUCTION:

The Migrant Health Program in Broward County has just completed its 19th month of operation. This report covers the first full season and first full calendar year of service.

The 1965-66 fall growing season in Broward County, marked by several untimely "blows" from the elements, and these served to deter full crop production. First, in October, 1965, there were several very severe rains and on one occasion as much as 26 inches of rain fell within a 24-hour period in the North Broward area. The farmers had just begun planting, and the heavy rainfall resulted in complete loss of early crops. In most instances fields were completely under water, some with as much as six (6) or seven (7) inches and were not suitable for immediate replanting.

The farm workers, for the most part, were residing in areas of poor drainage and almost a month had passed before the last traces of mud were gone. The Migrant Health Clinic located in the Pompano Beach Farm Labor Campdid not escape this deluge of water. The drainage canals north of the camp overflowed and deposited water in the lower-lying camp area, and for more than a week the Migrant Health Center had the unique distinction of being the only Health Center in the country completely surrounded by water. The Public Health Nurses waded back and forth to the clinic and were open for business as usual.

The second weather deterrent was a five-day freeze which occurred just as the farmers were recovering from the results of the rains. This again caused hardship on the farming community. Thankfully, the weather for the remaining season was good, but the early damage to the crops resulted in a million dollars less business than the previous season reported by the Pompano Farmers Market.

During this report year, it is estimated that there were about 8,000 to 9,000 migrant workers in the area during the peak of the season which occurs in December, January, February and March. Broward County is a base for migrants and they begin to return from northern crop areas in late September and remain until late March, at which time they begin the exodus cycle again. By late May the majority of workers are gone.

As stated in previous reports, the major camps in this area are slowly decreasing in numbers except for the Pompano Beach Farm Labor Camp. The people each year seem to return more and more to apartment dwellings within the limits of Pompano Beach, Deerfield Beach and Fort Lauderdale. Since the extent of their stay is longer in Florida than in any other area, it is becoming more usual for people to maintain an apartment in the communities just mentioned. However, to estimate the number of families that do this is extremely difficult. Too, families are broken during the season when some members go north and some stay in the area. The father, mother and older children may go north while the younger ones stay with relatives or friends. Sometimes a reverse pattern is evident when older children are sent "on-the-road" under the care of relatives and the parents remain in the base area.

Ethnically, the migrant population is composed of: Negroes, 40%; Puerto Ricans, 40%; Texas-Mexicans, 15%; and Caucasians, 5%. The Negroes, for the most part, consider Georgia or the Carolinas as their original home, but now look on this area as home. Some Puerto Ricans also consider Broward County as their home area and like the Negroes, often pay rent on a dwelling here even when they are away. The cost of holding a dwelling is about $2. a week. Other Puerto Ricans fly home for visits between seasons or may return there during the off-season months rather than migrating in the continental United States. The Texas-Mexicans are usually from the Brownsville area and most manage to return there once a year for short visits. This latter group works across the state and up the west coast of Florida. The Caucasians who were seen during this season come from northern Florida and North Carolina. They tend to work more in the packing houses, which is much more lucrative than in the fields.

The migrating patterns seem to be repetitive with the Negroes returning to areas in North Carolina, Virginia and New Jersey and some to Pennsylvania and upstate New York. The same families go with the crew leaders year after year and, as a rule, do not seem to change their leaders. This year the Puerto Ricans migrated to New Jersey and in contrast to the Negro migrant, used their own cars for travel. The Texas-Mexicans are a family-centered group and seem to function and travel as a unit. Occasionally they travel in large groups with a crew leader. This group moves for the summer to Ohio and Michigan and some to Indiana.

One of the unusual occurrences this past season was the large number of single Negro males who came into the area from Missouri and lived in the Pompano Camp. The single Puerto Rican male is not unusual.

Some of the migrants living in Broward County work in the fields far removed from their living quarters. For example: The workers from Pompano and Deerfield camps quite frequently work as far out as Lake Okeechobee in Palm Beach County, and the Homestead-Perrine area in Dade County, a distance of 60 to 70 miles.

FAMILY HEALTH SERVICE CLINICS:

In May, 1965, after the majority of migrant workers had gone "up-the-road", it was felt that one evening clinic and one day clinic would be adequate to serve the field workers who remained in the area between seasons and depend on agricultural work for their livelihood. Dr. R. O. Burry, who has been with the project since its beginning, served as Clinician. The clinics were held as follows:

Tuesdays	2:00 to 4:00 P.M.
Wednesdays	6:00 to 8:30 P.M.

At this time, Dr. Ian Ajac, an Internist-Allergist, joined the staff to complement Dr. Burry's services. The night clinics are very heavily attended by the adult population, while the day clinic was attended more by women and their children. It is felt that immunizations and other treatments can be more easily carried out in the day clinics to clear the traffic for the field workers who need treatment after returning from the fields. Children cannot attend the clinic without an adult, and if accompanied by a baby-sitter or relative must have a signed permission slip from the parent. In the beginning there had been a number of children dropped at the clinic door or just sent in for treatment, which made it necessary to adopt the policy mentioned above. By the end of the season this practice was at a minimum.

The clerical position was unfilled from November to January. Therefore, it was necessary that the nurse perform the clerical tasks as well as nursing duties. In January a VISTA worker, Miss Cheryl Campbell, joined the staff and worked part-time as a Clinic Aide. She was able to do some clerical tasks, but again, the bulk of the clerical work, including reports, etc., fell to the nurses.

During the winter months, the mobile unit was taken to two outlying camps on a monthly basis. The unit is not available to the Migrant Program at all times, as it is used over the entire county for immunization clinics. So that the unit could better serve as a mobile Migrant Health Clinic, a large closet was built on the unit for the storage of supplies, equipment, medicines and records. The unit does meet a need, but has some disadvantages including lack of privacy, cramped quarters and generator noise. The noise makes it difficult for the physicians and patients to hear each other.

In February, 1966 a Dental Clinic was started at the Migrant Health Center under the direction of Dr. Charles Coker, D.D.S. of the Broward County Health Department. Dental instruments were donated by Dr. Whitson, a local dental surgeon. Other equipment was received from the Broward County Dental Society and the Broward County Health Department. Two local practicing dentists, Dr. M. Dixon and Dr. T. Gallaher have alternated working at the clinic. The dental clinic is held during the regular clinic hours at the Migrant Health Center and is an important part of the total service offered to the migrant. With the opening of the dental clinic one nurse assisted the dentist and the other nurse assisted the physician, filled prescriptions and was responsible for general clinic operation. At times, as many as 60 to 65 people attended clinic and during these heavy clinics the personnel were extremely rushed.

All of the clinics are run on a semi-emergency care basis and there is no way to anticipate the types or number of cases that will be seen in the clinic. During the clinic sessions, as shown in the statistics, many and varied types of cases are seen. For example: One of the major conditions noted after the floods in the fall was generalized itching among many of the people. It was finally discovered that a mite which usually lives along the floor line in tropical area residences had been flooded out of its usual home and had taken up temporary residence in the furniture and bedclothes. Another patient came to the clinic with a bullet embedded in the inner surface of the thigh which was palpable, but was quite a distance from the original entry site. He had been patiently waiting for the clinic to open since the shooting was two days prior. After reporting the incident to the Sheriff, it was decided to let the bullet stay, as no further damage seemed imminent. The patient was instructed to return periodically to clinic to have his "bullet" checked.

The clinic staff also was proud of the improvement in one of their patients who came to them with generalized ulcers on both legs. He could not walk without crutches and had been unable to work in the fields for almost two years. During the two years he had traveled up and down the stream, visited many clinics and been hospitalized on several occasions. After medical treatment by Dr. Burry, the patient was free to pain for the first time in two years and the ulcers began to heal. At present, this man is able to work full-time in the fields and his legs have remained healed. Needless to say, this man is a great booster for the work of the clinic.

Table 1 shows the clinic sessions, hours and visits:

TABLE 1 - Migrant Health Clinic Pompano Beach, Florida
April 30, 1965 through April 30, 1966

Clinic Sessions	149
Clinic Hours	379
Patient Visits	2,785

There were 149 clinic sessions totaling 379 hours and 2,785 patient visits made during this reporting period.

Table 2 indicates by chom the patients were seen:

TABLE 2 - Type of Patient-Visits to Migrant Health Clinic Pompano Beach, Florida April 30, 1965 through April 30, 1966

Type of Visits	Total
Nursing	645
Nurse & Physician	2,140
Total	2,785

Two-thousand, seven-hundred and eighty-five patient-visits were made to the clinic, of these visits 645 were seen by the Public Health Nurse and 2,140 were seen by the Public Health Nurse and the Physician.

Since the beginning of the dental services, 105 patient-visits were made in 13 clinic sessions and 360 extractions were done. All patients in need of dental services are seen by the medical physician and then referred to the dental clinic.

Table 3 shows the distribution of the patient-visits by condition or disease:

TABLE 3 - Distribution of Patient-Visits to Migrant
Health Clinic Pompano Beach, Florida
April 30, 1965 through April 30, 1966
By Condition or Disease

Condition or Disease	Visits
Upper Respirators	654
Immunizations, Without Disease	441
Cardiovascular	228
Skin	220
Gastrointestinal	187
Traumatic	171
Neurologic	149
E.E.N.T.	148
Dental	119
Gynecologic	119
Intestinal Parasites	87
Venereal	56
Genitourinary	41
Obstetric	38
Communicable	34
Orthopedic	26
Allergic	24
Tuberculosis	23
Tumor	13
Arthritis	3
Psychiatric	3
Malnutrition	1
Total................	2,785

Upper respiratory, immunizations without disease, cardiovascular and skin disease or conditions accounted for 55% of the patient visits to the clinic. Gastrointestinal, traumatic, neurologic, E.E.N.T., dental and gynological conditions or diseases accounted for 32%. Intestinal parasites, venereal, genitourinary, obstetrical, communicable, orthopedic allergic, tuberculosis, tumor, arthritis, psychiatric and malnutrition accounted for the remaining 13% of the patient-visits.

Noteworthy, 1,877 prescriptions were issued and filled in the clinic. Twenty-one cervical cytology and 97 tuberculin tests were performed. Five patients received Family-Planning services.

Table 4 illustrates that slightly less than half of the patient-visits were made by less-than-fifteen age group:

TABLE 4 - Patient-Visits to Migrant Health Clinic
Pompano Beach, Florida April 30, 1965
through April 30, 1966
By Age and Sex

Age	Male	Female	Total
-15	652	670	1,322
15-44	378	520	898
45+	359	206	565
Total	1,389	1,396	2,785

Males and females were almost equally divided in patient-visits with 1,389 and 1,396 respectively. The less-than-fifteen age group accounted for almost one-half of the patient visits with 1,322 and the 15 - 44 age group had 898 and over 45 age group had 565 patient visits to the clinic.

Table 5 shows that 132 patients had to be referred to other sources for further service.

Almost one-half (60) of the patients referred for further service were sent to the County Health Department, mostly for x-rays, maternity and venereal disease services. Hospital referrals accounted for 25, Welfare Department 22, medical specialist 7, Veteran's Service 3 and one each to Tumor Clinic, Sheriff's Department and Vocational Rehabilitation. "Other" included 11 referrals for dental care before the establishment of dental services at the clinic and one patient was referred to a plastic surgeon for care.

TABLE 5 - Distribution of Patients Referred for further Service to other Sources from Migrant Health Clinic Pompano Beach, Florida, April 30, 1965 through April 30, 1966

Other Source	Referred
Health Department	60
Hospital	25
Welfare Department	22
Medical Specialist	7
Veteran's Service	3
Tumor Clinic	1
Sheriff's Department	1
Vocational Rehabilitation	1
Other	12

Total...........132

It was found that caring for the maternity patients during the generalized clinic hours was difficult. The clinic staff was rushed and did not have the time, nor space, for properly interviewing and examining the patient. Therefore, the maternity patients were referred to the regular maternity clinic at the Pompano Beach Health Department for care by an obstetrician. This arrangement seemed to work out well for both patient and staff. It should be noted that the staff of the Pompano Beach Health Department and the Migrant Program work closely together and frequent contact is maintained between the offices.

One of the most frustrating problems in clinic operation was the matter of hospital referrals. At times a patient would be seen in the clinic but would need additional diagnostic studies or medical treatment. In suchcases a referral was made to local hospitals only to have the patient return to the Migrant Clinic after being shunted around the community. Many patients were sent by the hospital emergency room to Dr. Burry's private office. There has been some improvement in hospital service since full-time physicians have been employed by the hospitals to staff their emergency rooms.

The North Hospital District made a survey of the use of the North District and Broward General Hospitals emergency room and In-patient hospital services by migrant workers for the first three months of 1966. The results of the study are as follows:

IN-PATIENT SERVICES:	Broward General Hospital		North District Hospital	
Month	No. of Patients	Total Charges	No. of Patients	Total Charges
January	9	2,005.00	2	837.00
February	7	1,795.00	9	3,509.00
March	12	2,029.00	12	4,207.00
Total	28	5,829.00	23	8,553.00
EMERGENCY ROOM:				
January	23	363.00	54	1,009.85
February	19	318.00	39	767.25
March	16	297.00	23	432.75
Total	58	978.00	116	2,209.85

Funds to support emergency room service to migrants at the County Hospitals will be included in the continuation request for funds.

Recently, a Social Service Worker was added to the staff of North District Hospital and since then a greater sharing of information regarding the outcome of cases and cooperative planning for their discharge has been evident. The Social Service Department at Broward General Hospital has been most helpful and cooperative in accepting patients for care. Interestingly, the hospitals frequently refer patients to the Migrant Clinic for treatment and even suture removal.

The patients who are referred to the Welfare Department are usually able to present some evidence of Broward County residence and they have received good care and follow-up.

Interpersonal relationship between the Project Staff and the migrant have steadily improved since the beginning of the program. With each month of clinic operation there is a better understanding of patient needs and how to meet these needs. The general increase in clinic attendance has come about mostly by migrants telling other migrants about the services available.

The migrant clinic is also a point of interest on the "tourist run" and a good deal of time is spent showing interested people through the clinic facilities. Although at times this is inconvenient for the staff, the good public relationships gained is felt to be worth the effort. Hopefully, with a full complement of staff, there will be more time in the future to work with lay groups in the community.

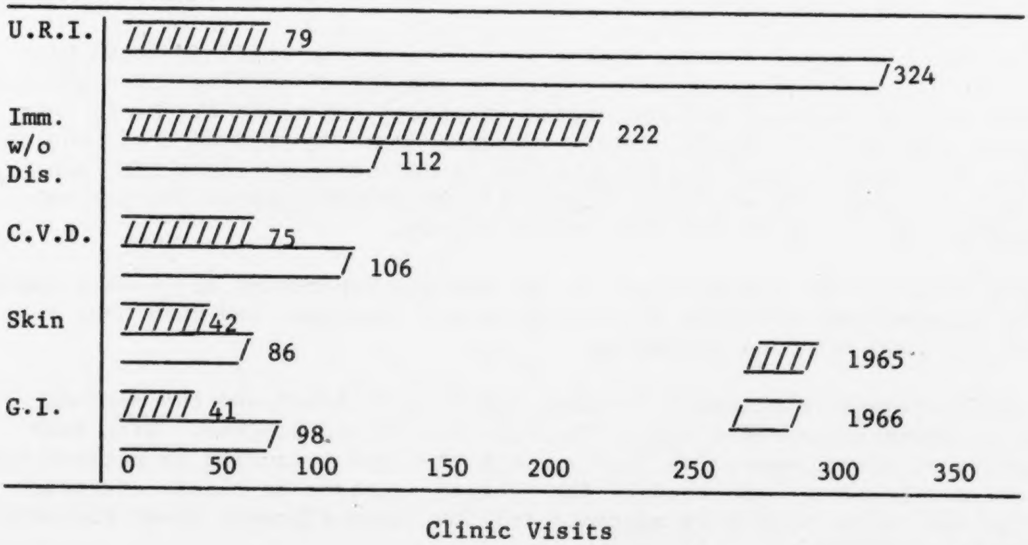
As to methods of education efforts, these, for the most part, have been on an individual or one-to-one basis. There has been a concerted effort to counsel with and teach patients on a personal basis and each patient has a chance to talk with the physician. Each person receives explanations and instructions regarding his condition, need for further care and purpose of the medications ordered. This again is reinforced by the nurse who hands the patient his medication, repease the instructions, gives future appointment dates and, if the patient is being referred, gives directions and arranges transportation.

So far it has been almost impossible to carry out any group teaching for many reasons, such as poor physical arrangements, crowded clinic, complete involvement of personnel with patient care and inability to keep full complement of staff. Another important fact is that the patient is frequently chronically fatigued and is anxious to get treated for his ailment so that he can go home to rest or sleep.

The strengths of the educational methods used in the clinics lie in the familiarity of the migrant with the staff, and his emerging belief that help is, and will be, available, should he need it. The people are coming to clinic when they are sick; they are following instructions better and are more regular in follow-up clinic attendance.

The increase in clinic visits for a sample period, January thru April, 1965 and for the same period of 1966 by five leading conditions or diseases is shown in Figure 1.

Figure 1 - Clinic Visits Migrant Health Clinic, Pompano Beach, Florida - January thru April, 1965 & 66 - By Leading Conditions or Disease:



NURSING SERVICES:

Public health nursing service was provided to the migrant and his family by two Public Health Nurses who devote 100% of their time to Migrant Project activities. A third nursing position was requested and approved for this fiscal year but the official notice came after the heavy work load of the season had passed. Therefore, the position has remained unfilled. The plan now is to transfer a Public Health Nurse from the General Program to the Migrant Program in July so that she will be fully oriented and ready to accept a full nursing load as the fall season starts.

The nurses assigned to the Migrant Project provide a generalized public health nursing service to the migrant community. These services include health teaching and demonstration in the areas of maternal and child health, family planning, school health, communicable disease control (including tuberculosis and venereal disease), and mental health and chronic disease.

The nurses function in both the clinic and home settings. In the clinic she functions as a team member with the physician and dentist, obtaining intake information, screening patients, assisting the physician, giving immunizations and prescribed medications, interpreting and reinforcing physicians orders to the patient, dispensing necessary supplies and giving health instructions and information to the migrant and his family.

In the field or home setting the public health nurses provide health teaching in the areas mentioned above, as well as functioning as a community resource person for health and related services.

Specifically, the nurses visit the two large outlying camps at least once a week and a great deal of work is done in and around these camps. However, it is difficult to reach the workers during the day, as the crews are moved frequently from field to field.

In addition to field and clinic duties, the Migrant Project Nurses provide services to the Public School and Child Care Center located in the Pompano Labor Camp. Several special projects in these schools have been carried out such as tuberculin skin testing and stool examinations for parasites.

The two Public Health Nurses made 590 field visits during the reporting period. The following shows a "breakdown" of these field visits:

Child Health Service:	
Under 1 year	123
1 - 4 years	17
Over 5 years	64
Tuberculosis	124
Maternity	89
Chronic Disease	43
Communicable Disease	41
Mental Health	8
Venereal Disease	6
Miscellaneous	75

The generalized nursing staff of the Broward County Health Department sees and visits migrant workers throughout the community. Some of these persons can be identified as migrants, but others cannot, due to the fact that they have become a part of the general community. Therefore, it is difficult to estimate the amount of support given to migrant project activities by the generalized nursing staff.

As pointed out earlier in the report, one of the problems encountered by the nurses is the reluctance of the local county hospital to accept referrals or to care for migrants in the emergency rooms. Provision for emergency and in-patient hospital care is one of the unmet needs in regard to comprehensive medical care for migrants.

A bright side is evident in some instances. Four women with positive cytology examinations were discovered by the clinic staff and were referred for further treatment. One of the patients chose to go to a private physician as she had some health insurance. She has been under his care and is completing treatment. The three other patients, with the assistance of the Welfare Department, have now finished cobalt therapy and at present are doing as well as can be expected. One other patient who was diagnosed as having cancer of the esphagus, has also been treated with cobalt.

Other problems such as lack of transportation have been partially met by the Vista workers. They were able to provide transportation for patients to keep appointments at State Welfare, Social Security, Vocational Rehabilitation and Surplus Food Offices. It seems that there is very little concern by migrants for other migrants in regard to the solution of problems. There are numerous cars in the camps but without pay, the owners will not provide transportation for each other.

A great deal of the nurses time is spent in trying to find solutions to the many and varied problems that the migrant presents. The Migrant Health Center seems to be a beacon for all those in any kind of trouble and solutions are not readily available. The Community Action Fund shares a great deal of the responsibility for medical and non-medical problems. At present one of the migrant workers who is paralyzed from the waist down is being housed in the Labor Camp. He was discharged from the hospital, but is not eligible for any sort of public assistance. Yet, this man must somehow be cared for. With assistance from the Hospital Social Service Department, Mr. Coble from Community Action Fund, Col. Dewy from Pompano Beach Farm Labor Camp and the staff of the Migrant Project; the man is being housed and fed. The patient does try to be self-sufficient and does work during the season by dragging himself along in the fields. During the off-season, he cannot find work and thus needs assistance.

One of the nurses serves on the Migrant Council of Broward County, which is a community organization to provide assistance to migrants in the event of a major freeze or other disaster. The scope by the Council's interest has broadened since its beginning, and it is hoped that they can eventually sponsor a half-way house for migrants. This would provide a place for the migrant to stay while he is convalescing after hospitalization and would prevent his becoming ill again.

Another agency that offers a great deal of assistance and insight for the solution of problems facing the migrant is the Employment Service of the Farm Labor Bureau. They have been most helpful in attempting to locate workers who are referred from northern areas.

The office of Economic Opportunity has employed a former midwife of the area, Mrs. Elizabeth Scott, to work in the migrant area as a Health-Aide. She has been a reliable and welcome ally in reaching hard-to-reach families. She is familiar with the mores and customs of the people and has been most helpful in exchanging and providing information to the nurses.

FUTURE PROJECT DEVELOPMENT:

This annual report has attempted to show how the original general and specific project objectives were met by the Broward County Migrant Health Program.

General Objective: To improve the migrant's health and those conditions affecting the health of the migrant.

Specific Objectives:

(1) To establish broad outlines of medical services to the migrant up which to develop and on-going program.

(2) To provide increased public health nursing services to the migrant.

(3) To provide regularly available family health clinic services to the migrant.

(4) To purchase and provide medical services to the migrant.

(5) To motivate the migrant to improve his health and health conditions.

(6) To establish and maintain adequate records of program activities and accomplishments.

Early in the operation of the program most of the project objectives were being met and additional ones were added. The need for sanitation services was evident from the beginning and a Sanitarian was added to the staff in November of 1965.

Dental services have long been recognized as a major need of low socioeconomic groups and after much ground work by Dr. C. Coker, a dental clinic for migrants was started in March, 1966.

The need for funds to provide emergency room and in-patient services is perhaps the most pressing need at this time. Funds for meeting these needs will be requested in the continuation report for the next fiscal year, but in the meantime, some solution is needed for the fall season of this fiscal year.

In trying to evaluate the results and progress made by the Migrant Program in meeting the health needs of the migrant, many factors were considered. However, very few conclusions could be made so only observations of behavior are reported.

It was noted that the migrants were more faithful about keeping appointments and more interested in following instructions.

Very little interest is becoming involved with community or clinic projects was evident. Health classes were held at the school in the camp and had fairly good attendance until the season really started, and then interest waned. Several women were approached regarding their interest in working as aides in the clinic but they felt that they could do just as well in field work.

The Texas-Mexicans seem to demonstrate more interest and appreciation of the services available to them. They are a father-controlled family group and they seem to function more effectively as a unit. Recommendations for follow-up by this group are always followed and quite often they make their own arrangements for necessary care. For example: One family member was referred to Anti-Convulsion Clinic in Miami and there was no question about the charges involved. This group of migrants usually maintains the family unit by keeping the mother in the home. She is responsible for the care of the children and contributes greatly to the stability of the home.

The language barrier remains a problem with the Spanish-speaking people. The staff is only able to give simple health instructions in Spanish. The employment of a Spanish speaking clinic aide or clerk would be ideal, but so far this has not been possible.

All in all the services of the Migrant Program are becoming widely known in the community and are being used to a great extent by those in need of the services. The contribution of the program to the overall improvement of the health status of the migrant would seem to be immeasurable.

SANITATION SERVICES

The services of one sanitarian have been utilized on this program since November 4, 1965. This person's efforts have been spent 100% on migrant-associated problems. Approximately 25% of the time of a Sanitarian Supervisor I was dedicated to this project. The Sanitation Directir II devoted approximately 10% of his time to directing the sanitation services related to migrants in Broward County.

Due to a vacancy existing in the clerical position part of the year, this type of work was required of the sanitarian and in some cases other members of the local health department staff.

NUMBER OF CAMPS IN AREA BY TYPE AND POPULATION

CAMPS	NUMBER	CAPACITY
Total Camps	24	
Permitted Camps	6	
Camps for Single Males	10	600
Camps for Families	14	3,400
		Total.....4,000

NOTE: The State Sanitary Code (Chapter 170C-32) was used as a basis to evaluate labor camps in Broward County.

SANITATION SERVICES RELATED TO CAMPS

TYPE OF VISIT:

Complete Inspection	20
Follow-up Inspection	39
Conferences:	
Operator	43
Resident Manager, etc	21
Contractor	4
Health Department Staff	13
Owner or Agent	3
Water Samples	30
Complaints	19
Dog Bites	2
Other:	
Sewage Disposal	14
Kitchen Inspection	6
Information	89
Total Visits by Purpose	304

When the sanitarian was hired in November of 1965, two camps were officially permitted. The paper work of five more was almost ready for permitting. These were permitted to bring the total permitted camps to seven.

During the season one of these camps burned to the ground. It was not occupied at the time. It was speculated that squirrels or mice tampering with the wiring may have caused the fire. It has not been rebuilt.

In the Broward County area there are fifteen camps which are in the process of being put on legal notice to make improvements to meet Code requirements. A numerical number of defects in these camps would be too numerous to count. Corrections this year were made in the areas of safe water supply, the use of portable chemical toilets, garbage control and/or sanitary nuisance correction.

EXAMPLES:

One farmer had no flush toilets; migrants were using the woods or insanitary privies. After talking with the farmer he agreed to rent portable chemical toilets. The farmers who use this type of unit (five of them) are of the opinion that it is more workable than a flush toilet. It is a costly unit (approximately $20. per month per unit), but when balanced against plumbing costs, its ability to dispose of slop pail refuse, the companies cleaning service (toilet paper included) and the lessening of the operator's aggravation, the cost is worth it.

One farmer's water sample was continuously reported unsatisfactory for drinking purposes. He was operating on leased land with a verbal lease and did not want to drill a new well. He installed a commercial chlorinator. Other farmers followed chlorination of private well procedure and were successful in eliminating contamination.

Trailer waste was being piped into an open ditch. The operator was given a legal notice for a sanitary nuisance. To remedy the condition toilets were shut off and portable chemical toilets installed as a temporary solution.

Septic tank lines were flowing on the ground. A legal sanitary nuisance was given to the operator. Plumber called repaired all leaking toilets and sinks, pumped out septic tank and replaced drain field.

Garbage was piled in the rear of camp grounds. Legal sanitary nuisance was given manager. Dumpster was rented and four times a week service given.

There were many reasons for not correcting the defects that remained. Some are:

(1) Our program started in the height of the season when everyone was using any quarters they had to maximum capacity.

(2) The sanitarian needed time to become familiar with the problem and the area.

(3) The migrant's willingness to live anywhere as long as it is free. His lack of responsibility for himself, his home, his wife, his children. His often being an alcoholic and having the problems of this type of person.

(4) The farmer's reluctance to spend money on improvements that he figures will only be destroyed.

(5) Trailers being used in violation of Country Trailer Park Laws (Photo #1). The farmer has these outs:

1. Apply for a special variance.
2. One trailer per five acres.
3. Trailer park zoning.

(6) The size of many migrant families includes up to fifteen children. Much of the farming in Broward County is done on leased land. Due to the rapid population growth in this county, most leases are for three years with a clause that during any year of the lease should the land be needed or sold for real estate, subdivision or development, the farmer will phase out his crops and the lease terminated. Cooking - the migrant usually cooks on a kerosene stove that ruins the quarters. Also, there is a definite lack of field cooking facilities. Many of Broward County camps are small but have the problems of a larger camp.

Broward County is the home base for many migrants. They live in the low income sections of:

Deerfield Beach............400

Pompano Beach	1,000
Carver Homes	200
Collier City	400
Fort Lauderdale	1,000
Unincorporated areas	3,000
Estimated Total	6,000

Some migrants have homes that they come back to; others rent houses, rooms, or apartments.

There are many migrants who work in packing houses, run machinery, etc. They live in the better sections of the area.

Laws, regulations and other criteria for evaluating housing not located in the camps include:

Hotel and Restaurant Standards
Building Codes of:
  City of Deerfield
  City of Pompano
  Broward County

Deerfield and Pompano Beach have condemnation programs to help eliminate quarters with less than minimal facilities. The County has condemnation powers but as yet has not used it.

TOTAL NUMBER OF VISITS MADE TO OTHER THAN CAMP LOCATIONS BY PURPOSE OF VISIT

	NUMBER	TOTAL VISITS
Water Samples	8	10
New Septic Tanks Installed	15	16
Schools	(In May)	
Mobile Home Parks	1	1
Child Care Centers	1	2
Complaints Investigates	27	94
Nuisance Corrected		22
Rabies - Animal Bites	11	31
Eating and Drinking Establishments	7	12
Grocery and Meat Markets	9	11
Private Premise	26	39
Public Premise	9	13
	Total..114	Total.251

Because Broward is the home base for so many migrants, this area has just been touched on. Many community problems can be traced to the migrant being absorbed as a permanent or semi-permanent resident. The total number of shack-type quarters he has to live in has been reduced but his lack of knowledge of basic sanitation has created new slum areas. Instead of the old shack messes there are now many new apartment messes. Again the problem of responsibility crops up. Why is a new apartment so dilapidated in a short period of time? Each case has its own answer and many times knowing the reason does not help much. Problems of overcrowding, lack of responsibility, unsupervised children, poor common sense, etc., can all be found but to correct the problems created is sometimes seemingly impossible. This is very frustrating to all concerned, including the migrant.

An attempt is being made in the areas of general migrant use to improve garbage removal and instill some kind of responsibility in the migrant's way of life. The aim is to remove the stigma of, "It's for the migrant, what do you expect?", in terms of the facilities he uses, from his garbage can to his school. Expect more from him and those he deals with and you may get it.

FIELD SANITATION:

Generally speaking, this area has been neglected. Efforts have been made to find a suitable field toilet facility as the County Building Department will not issue pit privy permits.

Much of the water for these fields is carried from camp spigots which are periodically checked.

A problem that needs solution is the food supply for these people in the fields. A great deal depends on the rebuilding of the Pompano Labor Camp. This would crease thirty approved kitchens from which these people could be fed.

PURPOSE AND METHOD OF EDUCATIONAL EFFORTS:

Most of the educational efforts this year were aimed at getting the farmer and/or the operator to recognize his problem and search for a solution. The solutions have ranged from cleaning and maintaining to total rebuilding or abandonment.

In camps where garbage storage or disposal is a problem, the person in charge is contacted and a system set up. In some cases a clean-up man is provided and he needs to be reprimanded. Attempts have been made to try to get the people in charge to understand that a problem exists in most instances due to the migrants' lack of responsibility and by not demanding more from the migrant, they feed this lack.

GROUP COUNSELLING:

The sanitarian and Hotel and Restaurant Commission agent were called on by the Economic Opportunity Fund Agency to give a talk on their role in community sanitation. The main aim was to try to coordinate activities of the agencies as far as garbage and trash control are concerned.

TYPES OF INDIVIDUALS OR GROUPS WITH WHOM WORKING RELATIONSHIPS WERE ESTABLISHED.

Florida Hotel and Restaurant Commission:

A joint effort was made in the Pompano area in relation to garbage control, removal of kerosene heaters and upgrading of apartments. An attempt is still being made to discourage kerosene stove cooking, but as yet it has not been too successful.

Housing Authority of the City of Pompano:

Negotiations are in progress to rebuild the Pompano Labor Camp which is one of the largest migrant farm labor camps on the Eastern seaboard. They are in the process of trying to acquire funds from the Farmers Home Administration. This involves a grant of $750,000. and Bonded loan of $1,250,000. To date, this has not been approved due to a certain amount of red tape. At present they need court clearance of their bonds which can bog down indefinitely. They have been trying to rebuild since 1960 and have worked on this approach since 1963. This camp was built in 1942 to meet minimal standards and is in definite need of upgrading. Two-million dollars is a substantial amount of money but it would be used in one of the places where it is most needed.

Building Department of Deerfield Beach, Pompano Beach & Broward County:

A cooperative effort is being carried forward to remove shack-type structures and prevent the creation of more problems.

County Solicitors:

A review of the migrant situation for legal guidance has been requested as to the appropriate course to pursue.

Portable Toilet Operators:

Are attempting to solve some of the human waste problems of the migrant.

Community Action Fund:

Attempt to coordinate activities where they are most needed for the migrants' benefit.

Community Action Program:

Exchanging information in an attempt to eliminary or alleviate problems. Housekeeping, education and child care centers are included in a program to aid the migrants.

Provisions made for Orientation, In-Service Training or Other Indoctrination:

Sanitarian attended the Migrant Health Conference held in December, 1965.

Two weeks of observation with Pompano sanitarians and supervisor.

Sanitarian Section meetings which involved general sanitation problems.

Problems in Project Operation:

The migrant Sanitarian started in November which was the height of the season. Much of the sanitarian's effort was spent eliminating sanitary nuisances and trying to lay the groundwork for major improvements during the summer. It appears that the migrant himself is a problem due to the type of work he performs and the usually accepted but poor environment he frequents; a particular caliber of person is attracted.

The flush toilet many times creates a problem for these people. They stand on it so they won't have personal contact with it. They put bottles, cans, clothing, rocks, sand, etc., in it which causes it to malfunction. They get drunk and fall off it and break it. They sometimes rip it out of its setting. Portable chemical toilets have been used with what has been felt much success. They are not the ideal, but they work. Due to the nature of the leases in Broward County, they are tentatively going to be allowed in conjunction with wash facilities in some instances.

An attempt is being made to find a portable chemical toilet to use in the field, but cost and practicality hampers this effort.

Camps have been operated with no responsibility or chain of command. To get or train migrants or crew leaders to accept this responsibility which the farmers during the height of the season don't have time for, is being overcome but will take time. Camp owners or operators have in many cases accepted the fact that they need a full-time clean-up or maintenance man. The quality of this man often determines the conditions in the camp.

The migrant has cooked on kerosene stoves for years. It is impossible to keep quarters clean and use this type of stove. Gas stoves are economical and desirable but the cash outlay for deposit (est $10.), fuel, (est. $10. tank) and installation (est. $20. stove) hampers the change from kerosene.

Most migrants are like small children; unless someone stands over them or tells them exactly what to do, they won't do anything. In order to get results, it many times takes personal contact with each migrant. Apartment houses that have been built with complete facilities become dilipidated in a matter of just weeks. Garbage control gets out of hand and to correct the situations takes weeks. Due to the size of migrant families and often the lack of a father, vandalism in terms of broken windows, doors and littering of the surroundings seems inevitable. Too many children with improper or no supervision is a constant problem.

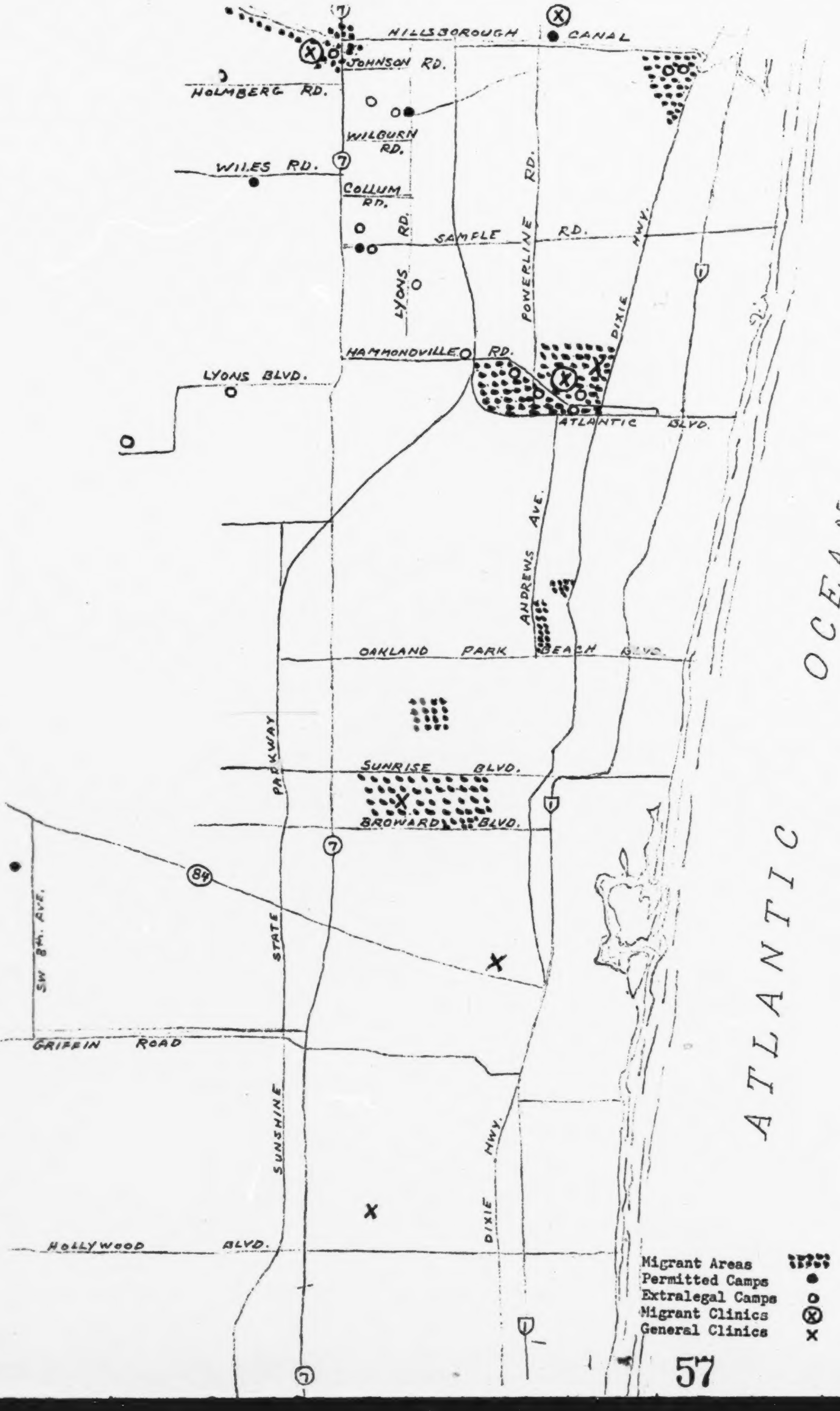
Pompano Beach and Deerfield Beach are the major migrant areas. Each of these communities has extensive condemnation programs aimed at removing shack-type living. Pompano Beach's Fire Department cooperates with the owners in supervised burning of many of these condemned shacks or houses. Both of these communities run constant clean-up campaigns in their migrant areas. The County has condemnation powers but as yet has not used them. It is hoped that in the future the County's cooperation will increase.

Broward County is the home base for many migrants. This poses the problem of identification. Many families will stay in the area all year with one or more members going north during the summer. Therefore, much of our indigent population is migrant. The major effort in these areas has been in garbage and trash control coordinated with an effort to up-grade public facilities as grocery stores, bars, restaurants, schools, etc. Due to the vastness of this area and the detail involved, only the surface has been scratched.

It is believed that camp conditions will show a marked improvement during the summer months. During the season, many situations were tolerated with the aim towards total improvement during the summer. It remains to be seen whether the expected improvements will prevail through the remainder of the year.

Due to the individual personal contact needed to educate the migrant, health education is slow. It is felt that the area of most need here is in developing self-pride in the migrant.

Next season most of the bean farmers are going to use picking machines. This in many instances is going to mean a lesser need for migrant pickers. The bean picking industry has used many migrants who can do little else Many of the alcoholics and lazy migrants are going to find it hard to find employment. The farmer will still need migrant labor, for he can often get a better price and more production by using good migrant labor. It is hoped that this machine will help the farmer to be able to demand a better caliber of labor and in this way help the migrant to be a better person.


HILLSBOROUGH CANAL
JOHNSON RD.
HOLMBERG RD.
WILBURN RD.
WILES RD.
COLLUM RD.
LYONS RD.
SAMPLE RD.
POWERLINE RD.
DIXIE HWY.
HAMMONDVILLE RD.
LYONS BLVD.
ATLANTIC BLVD.
ANDREWS AVE.
OAKLAND PARK BEACH BLVD.
SUNRISE BLVD.
BROWARD BLVD.
PARKWAY
STATE
SUNSHINE
SW 8th AVE.
GRIFFIN ROAD
DIXIE HWY.
HOLLYWOOD BLVD.
7
1
84
ATLANTIC OCEAN
Migrant Areas
Permitted Camps ●
Extralegal Camps ○
Migrant Clinics ⊗
General Clinics ×

COLLIER COUNTY HEALTH DEPARTMENT

C. L. Brothers, M. D., Director

Area of County: 2,032 square miles

Resident Population: 22,000

Number of Migrants: 12,750

Migrant Project Staff:	2 Public Health Nurses
	1 Sanitarian
	1 Equipment Operator
	1 Dental Assistant

MIGRANT SITUATION

COLLIER COUNTY

The migrant season in Collier County for the reporting period followed much the same pattern as in the preceding period, but there were significant differences. At the peak of the season, there were approximately 6,000 migrant workers in the county, accompanied by an estimated 6,750 dependents. Acreage planted to crops increased over the previous season by 20%. Thus, there was a chronic shortage of field labor from the very beginning. An untimely freeze which occurred just as the early plantings were emerging required re-planting. This delayed harvesting of early crops, such as tomatoes, peppers, cucumbers, squash, etc., and these crops were ready for harvesting at the same time watermelons and cantaloupes were ready. This converted what had been a chronic shortage of labor into an acute one. During the final few weeks of the harvest, hourly wages up to $3.50 were offered, with too few takers. Regrettably, many crops were left in the fields, unharvested, at great financial loss to the growers. This situation may adversely affect our efforts to upgrade labor camps owned and operated by growers.

Ethnic backgrounds, as in prior years were roughly: 30% Texas-Mexicans; 25% Caucasian; 25% Negro; and 20% Puerto Rican.

Arrivals started around October 1 and most departures had occurred by May 31.

Lines of travel were roughly the same as in prior years: A majority follow the Atlantic states, but many go to and from Colorado, Texas, Ohio, Michigan and Wisconsin. Late spring freezes in northern states which destroyed the fruit crops may result in alteration of the pattern of travel in 1966.

Approximately 50% of the migrants consider Collier County as their home area, but their mode of living precludes establishing of local and state residency requirements. They are, therefore, excluded from any county or state welfare benefits.

Labor camps in operation totalled 106, and varied in capacity from 15 to 250. (See Sanitation Services and map of Collier County.)

The labor shortage which existed is due in large part to insufficient and below-minimum standards labor housing. There are signs that this may have been a blessing in disguise. A significant number of growers have reached the obvious conclusion that in order to be competitive with other areas for the available labor supply, more and better housing must be provided. Some have built modern camps, and others have verbally agreed to take action between "seasons" to upgrade existing sub-standard housing.

FAMILY HEALTH SERVICE CLINICS

In the Immokalee Clinic, which serves about 96% of the migrants in the county, the clinic schedule is as follows:

CLINIC SCHEDULE

MONDAY:	
MCH RN Conference, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 1:30 P.M.
Project "M" RN Conference, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 4:00 P.M.
TUESDAY:	
Family Planning, 1 Nurse - Second Nurse	Only when necessary
Project "M" RN Conference	
WEDNESDAY:	
MCH & Medical Clinic, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 3:00 P.M.
Project "M" RN Conference, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 4:00 P.M.
THURSDAY:	
Immuniaations	9:00 A.M. to 12:00 Noon 1:00 P.M. to 4:00 P.M.
Family Planning & Project "M" RN Conference (1 Nurse in A.M. - 2 Nurses in P.M.)	
FRIDAY:	
Project "M" RN Conference, 1 Nurse	9:00 A.M. to 12:00 Noon 1:00 P.M. to 4:00 P.M.

Naples clinic day is Monday, but drop-ins are seen at any time during office hours. A majority of migrants in the Naples area are seen in the emergency room of the Naples Community Hospital, which is staffed on a 24-hour basis seven (7) days a week.

Everglades Clinic is operated on a full-time basis by a public health nurse. A physician holds medical clinic once a month. There are very few migrants in this area.

The Immokalee Clinic had two full-time (one Project M) and one part-time public health nurses, and two full-time clinic aides - interpreters. In April, 1966 a second project nurse was added to the staff.

Two full-time and two part-time nurses staff the Naples clinic.

All clinic sessions are conducted in Health Department buildings.

Ill or injured patients were given referrals to private physicians. Table I (attached) shows referrals by diagnosis, sex, age group and ethnic group, but does not include re-visits for the same illness or injury.

FAMILY HEALTH SERVICE CLINICS
PROJECT "M" - MEDICAL REFERRALS TO PRIVATE PHYSICIANS

TABLE #I

		WHITE					MEXICAN				
DIAGNOSIS	SEX	0/1	1/5	5/15	15/45	45/+	0/1	1/5	5/15	15/45	45/+
Anxiety	F				2	1			1	2	1
	M				1					1	
Arthritis	F										
	M										
Cardio Vascular	F					2				2	
	M		1			10					3
Comm. Diseases	F	1	4	2	3		4	6	3	2	
	M	2	2	4	1		3	10	2	2	
Dental	F								2		
	M										
Diabetes	F				1						
	M										
E.E.N.T.	F		3	7	1		15	13	3	8	1
	M		1	1	1		4	5	5	1	2
Epilepsy	F				1			1	1	2	
	M				1				1		
G.I.	F	4			2	1	8	4	1	1	
	M	2			1		10	3	1	1	
G.U.	F				3			1		4	
	M	1			3	1				1	
Hernia	F										
	M								1		1
Minor & Major Injuries	F			2	1			2	1	4	
	M				7	10		2	3	1	1
Nutritional Diseases	F			1					2	2	
	M		2	2			1			1	
Tumor	F										
	M	2				1					
Gyn	F				4	1				1	7
	M										
Orthopedic	F				2	2			1		1
	M			1		1				2	2
Skin Condit. & Infect.	F		3	5		2	3	9	14	3	
	M	2	2	1	7	7	2	11	3	2	4
T.B. Suspects	F										
	M				1	1					
U.R.I.	F	2	4	1	1	3	24	43	15	9	2
	M	1	8	3	8	11	37	21	14	3	
V.D.	F										
	M										

(NOTE: THIS TABLE IS CONTINUED ON NEXT PAGE)

TABLE # L (CONTINUED)

		NEGRO					
DIAGNOSIS	SEX	0/1	1/5	5/15	15/45	45/+	TOTALS-White, Mex & Negro
Anxiety	F						7
	M						2
Arthritis	F				1		1
	M						
Cardio Vascular	F				2	1	7
	M				1	24	39
Comm. Diseases	F		4	1			30
	M	1	4	5			36
Dental	F				1		3
	M			1	1		2
Diabetes	F					1	2
	M						
E.E.N.T.	F	1			11		63
	M		1				21
Epilepsy	F						5
	M				1		3
G.I.	F				1	1	23
	M	1				4	23
G.U.	F			1	5	1	15
	M					1	7
Hernia	F				1		1
	M				1		3
Minor & Major Injuries	F				4		14
	M			1	10	2	37
Nutritional Diseases	F				2		7
	M			1			7
Tumor	F				2		2
	M						3
Gyn	F			10			23
	M						
Orthopedic	F			1			7
	M		1		2	2	11
Skin Condit. & Infect.	F		1	2	1	1	44
	M	1		1	4	5	52
T.B. Suspects	F						
	M			1	3	3	9
U.R.I.	F	1	7	2		1	115
	M	2	5	1	5	19	138
V.D.	F				1		1
	M				6		6
TOTALS		135	184	121	184	145	769

Approximately 300 patients were treated in our clinics with drugs provided by the state, county, drug manufacturers and private physicians. This represented a saving to the project of approximately $2,000.

Table II lists patients referred to clinics outside the county and transported by the project bus and equipment operator. A conservative evaluation of the worth of these free services would be $12,160.

Table III depicts number of migrant patients given dental services. The only cost to the project was the salary of one dental assistant. Priced at a modest $40.00 per patient, these services represent a contribution to the project of $23,[illegible]00.

Table IV lists other services provided to migrants, as well as to other indigent patients. From this table it is readily apparent that the bulk of the clinical work load in Collier County is provided to migrants. This involves the full-time efforts of the project personnel, as well as a generous portion of the time of non-project nurses, nurses aides and one physician.

Two young ladies from the VISTA project did yoeman service for the migrants in many ways. During October, November and December they did preliminary visual acuity screening on 731 children in the Immokalee schools. During this same period they assisted our dentist in a dental survey of all elementary school children in the area. From October through March they transported 326 children from Immokalee to the dental clinic in Naples. (Since that time the School Board has provided a bus and driver for this purpose with funds obtained from the Anti-poverty program.) They assisted in the mass chest x-ray survey in February, and later assisted the nurses in follow-ups of suspicious cases. During National Dental Week they distributed dental literature and showed a film on dental hygiene to all elementary school children. Starting in March, they assisted the nurse in doing vision re-checks on school children, for a total of 54. Following this they wrote letters to parents requesting that they consult with the PHN regarding the childrens' eye problems. They assisted the nurse in doing skin and scalp inspections on 633 children and sent 97 letters to parents asking that the parents consult with the nurse. On several occasions they assisted the nutritionists in conducting evening classes for parents on the subjects of proper diet, food budgeting, etc.

A nutritionist-trainee was assigned to the project by the state in February 1966 under the guidance and supervision of senior nutritionists from other areas of the state. Although ostensibly a trainee, this young lady has shown commendable initiative and enthusiasm in providing consultative and educational services to migrants, both as individuals and in groups. It is sincerely hoped that a replacement will be provided when her tour of duty is completed.

Because the clinic work load consumed a disproportionate amount of the nurses time, efforts in the field of health education were reduced to a disconcerting minimum. The part-time health educator assigned to the project resigned early in the "season," and no replacement was forthcoming. As stated, the nutritionist took up part of the slack. Every effort will be exerted during the next season to increase the number and frequency of home visits as well as educational activities in the clinics.

No evening clinics were held during the reporting period because of personnel shortages. We plan to reinstitute this activity during the next season and will continue if it proves to be productive.

Full medical support, including physical examinations, full immunizations, vision and hearing screening, tuberculin testing and referrals for treatment were given to 154 pre-school children in Project Head Start during the summer of 1965.

Family planning clinics were well attended, though there were too many drop-outs. This activity is receiving high priority by all professional personnel.

COLLIER COUNTY

MIGRANT HEALTH PROJECT REPORT

Sanitation Services Related to Migrant Housing and Work Locations:
(The format for this section follows Data Sheet IV)

1. The entire staff of the Environmental Health Section of the Collier County Health Department participated in this program. They are the Sanitation Director I, part-time; a Senior Sanitarian, part-time; one Sanitarian, part-time; a Clerk-Typist II, part-time; a Sanitarian, full-time. All of these workers are salaried.

2. The camps are located as shown on attached map. The distance between camps varies from a few feet to 26 miles. It is 42 miles from the Naples office to the Immokalee office of the Health Department.

3. The standards for evaluating the camps are the Florida State Sanitary Code and the Collier County Building Code. A labor camp is defined as any camp with 15 or more persons.

4. The camps vary in size from the minimum of 15 persons to over 250 persons:

   30 Camps for Single men - 16 to 240 persons.
   1 Camp for single women - 40 persons.
   25 Camps for mixed single - 15 to 150 persons.
   50 Camps for families - 15 to 250 persons.

   There were 1,942 female workers.
   There were 4,000 plus male workers.
   There were 2,00 plus children under age 13.

5. The total number of camps visited was 106.

Number of camp visits:	Sanitarian	Sen. Sanitarian	Dr. San.	Total
Water Supply................	181	1	1	183
Sewage, Garbage, Nuisance...	254	26	42	322
Permits and Inspections.....	469	10	47	526
Miscellaneous..............	93	9	19	121
Totals	997	46	109	1152

There are no public water supplies or sewage systems in camp areas, with one exception. Pollution of wells with sewage is frequently reported. A public water supply has been authorized for the Immokalee area. This supply will service more than half of the migrant population when completed.

The number of camps that met the standards at the beginning of the season was 38.

The number of camps brought up to standards during the season was 36.

The number of camps that met standards before they opened was 74.

Permits were obtained for 60 camps, with 14 camps with minor defects operated but were not permitted.

The defects found by type were as follows:

Overcrowding	105
Water and Plumbing	69
Sewage, Garbage, Nuisance	90
Maintenance	69

The defects corrected by type were as follows:

Overcrowding	73
Water and Plumbing	36
Garbage, etc	57
Maintenance	36

The correction of defects was obtained by the method of direct persuation through conversation with individuals such as owners, managers and tenants. There was a shortage of 1,500 beds in the county. Bunk houses were set up in empty store buildings as in previous years. Fires destroyed 175 beds in 7 camps with 4 deaths and destruction of 13 buildings. Several camps were built without our knowledge or permission. These camps contained serious health hazards of overcrowding, fire exposure, water supply, garbage, sewage, etc. An additional 250 new beds were added in modern fire-resistive buildings (concrete floors, walls and ceilings), all containing inside bathrooms.

In our opinion the major reasons for our failure to obtain the correction of the remaining defects are lack of personnel to give sufficient time to the program and indifference on the part of the owners, operators and local government representatives.

Comparative data from other years show the following:

1964-65 season there was a shortage of 2,000 beds. There were more workers last year. Eighty-two rooms were constructed with modern baths last year.

Camps permitted:	1965-66 - 60	1964-65 - 77
	1963 - 18	1962 - 38

6. Other types of housing used by migrants was Naples Airport. This consisted of a number of old barracks buildings which had been made over into apartments. They were considerably run down and dilapidated. Four-hundred migrants lived in the buildings for periods of 2 weeks to 2 months. The buildings were condemned and as soon as they were vacated they were burned by the fire department. It is estimated that 600 migrants lived in single-family residences in the Immokalee area. Uncounted numbers of migrants lived in trailers, single-family, duplex and apartment houses in the adjacent counties and were trucked or bused into work.

7. The Florida State Sanitary Code and the Collier County Building Code are used as a criteria for evaluating housing. Septic tank permits are required.

8. Sanitation services to migrants outside of camps are not recorded separately and the figures are not available.

9. Twenty-seven field locations were visited and recorded. (The total number of fields in the county are in the thousands.)

10. There are no field sources of water supply for drinking purposes known to the department. They probably wash their hands in a ditch as every field is surrounded by drainage ditches. Drinking water and soda pop is carried on the buses.

11. Nine field locations were visited to inspect privies. The common violation was open seats. Total number of violations would equal the number of privies which is unknown. This defect was not corrected.

12. Florida State Sanitary Code used for evaluation of field sanitation.

13. Our educational efforts are limited to efforts to talking to individuals. We talked to migrants, to management, to growers, to packers, to shippers and to others. We did not talk to any groups.

14. Owners and managers of all camps were advised regarding the minimum requirements of the code and maintenance.

15. No persons were counselled on a group basis.

16. Public health nurses, growers, crew leaders and camp operators were used as contacts for information purposes.

17. During the annual teachers project for academic credits we stress the migrant situation. We also hold staff meetings of our personnel. We encourage our personnel to attend regional health group and FPHA meetings. We participate in a variety of migrant seminars and courses.

18. Some of the major problems that hinder growers and others is the provision of adequate housing for migrants:

    A. One-year land lease contracts.
    B. Indifference or ignorance of basic problems.
    C. Inflexible codes for building, sewage and water.
    D. Red tape delaying the approval of proposed projects.

Problems that hinder the maintenance of housing:

- A. Indifference of migrant and tenants.
- B. Money.

Problems that hinder the migrant in maintaining housing or field sanitation facilities:

- A. Lack of education. They often do not know how to use the simplest facilities.
- B. Illness.

19. There is some improvement evident when the migrant is provided with better housing.

Camp owners have definitely improved in their attitude toward the building of permanent-type housing of better grade than previously built.

Some of the church groups and the migrant committee are interested as well as the Chamber of Commerce of Immokalee.

The owner-migrant relationship is very poor. Crew leaders are the contacts. Many migrants do not know for whom they work and who pays their wages. Crew leaders often take labor to other areas to honor commitments before the season is over. Some of the workers are in the fields only two or four days a week due to alcoholism.

The foremost disease is parasites. (Alcoholism is actually the worst in adults but is not directly connected with housing.)

It was and is not possible to serve all camps. The sanitation staff is too small to cover the large area as frequently as needed. The hidden nature of newly constructed camps makes a search necessary. The present position of "sanitarian" should be upgraded to "senior sanitarian" and an additional "sanitarian" is needed in order to enable the Environmental Health section to catch up with and do an adequate job of providing sanitation services as far as Migrant housing is concerned.

The health education needs are not met. It is obvious that if sanitarians cannot find time to do their regular duties they are not going to be able to do health education.

We have two (2) suggestions: Make legal assistance available, not on a local level or subject to local control, to any county that cannot get local enforcement. Increase the number of migrant sanitarians in Collier County.

NURSING SERVICES

Project "M" full-time nurse - One (thru March, 1966)
Project "M" full-time nurse - One (April)

Full-time non-project nurse - One

Half-time non-project nurse - One
Part-time (15%) non-project nurse - Three
Full-time clinic aide-interpreters - Two
Full-time volunteers (VISTA) - Two
Full-time social workers - Four (*)

(*) Paid for by School Board with Anit-Poverty funds. Worked closely with Health Department

Information on migrant camps is given in other sections. Nursing visits to migrant camps was on a case basis. The number of such visits was drastically reduced as compared with the previous season because "sick call" lasted nearly all day, and required the nurses presence in the clinic. For the same reasons, no regular schedule of nursing visits to camps could be maintained.

Information on patient referrals to physicians and clinics is given under Clinic Services. No patient who exhibited a genuine need was denied treatment by a private physician, a clinic physician or by the physician on call in the hospital emergency room. No in-patient hospital services were provided under the program.

All prenatal patients received personal counselling by the nurse and nutritionist. Over 200 patients received counselling on family planning. Educational efforts by nurses were confined to individuals and small groups. Contacts with growers, camp managers and crew leaders were handled by the sanitarians.

Demand for definitive medical and surgical services increased drastically over the previous year. As stated above, this demand required curtailment of many worthwhile activities not directly involved in care of the ill and injured.

School health program received high priority as in other years and involved all project and non-project personnel. Expansion of enrollment in existing schools, plus addition of another elementary school in Immokalee, meant a significant increase in the work load in this area.

Tuberculosis screening showed positive results. During the calendar year 1964, eleven Collier County patients were admitted to State T.B. hospitals. During 1965 thirty-one were admitted to T.B. hospitals, one died soon after admission to Naples Community Hospital with acute miliary tuberculosis and one infant was treated at home. (*)Some of them with active tuberculosis "got away", due to lapse of time in receiving x-ray and laboratory reports. Some alcoholics and drug addicts were aware that they have active disease, and when subjected to x-ray and laboratory study, will "bug out" for parts unknown in order to escape compulsory hospitalization. (*) A large majority of these patients were migrants.

The staff worked closely with school officials, church groups, migrant committee, law enforcement agencies, county government, day care centers, private physicians, hospitals, outside clinics, and other agencies in insuring that the medical needs of migrants and their families were met. It would be utopian to expect that in two "seasons" the recipients of these services would be fully aware of the services available to them.

However, it has become increasingly apparent that a large majority are aware of services available; that they seek assistance in increasing numbers; and that many benefit from such contacts in ways not directly concerned with treatment of illnesses or injuries. Of significance is the large attendance at our immunization clinics; offsetting this is the high incidence of measles, even though measles vaccine was made available at cost ($2.00 per child). Measles vaccine should be included in the free vaccines supplied by the State Board of Health.

Practicing physicians, hospitals and clinics cooperated fully with the Health Department in providing health services for migrants. Many contributed their services without demand for or expectation of remuneration.

The original project nurse has become eligible for upgrading to PHN III and action is under way to accomplish this. This young lady has a missionary devotion to the cause of improvement to the lot of the migrants and she has demonstrated that her impending promotion is richly deserved.

HEALTH EDUCATION SERVICES

As stated under other headings, accomplishments in this field were grossly inadequate. Contributions to this were:

(1) No full-time or part-time health educator was available during the "season."

(2) Daily schedules of other project and non-project personnel were so crowded with other activities that time was not available for more than personal counselling of individuals on a case basis.

Some positive results were obtained in the fields of dental health and nutrition. (See other sections.)

With two full-time project nurses and two full-time clinic aide-interpreters available at the start of the next "season", efforts in the field of health education will be intensified. Addition to the staff of a full-time or even half-time health educator would greatly augment their efforts.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

As related in other sections, home and camp visits by nurses and educators were restricted and inadequate, hence there was little opportunity to study the migrants in their home environment. If any of them possessed any unusual potentials, they were not discovered.

The sanitarians attempted to interest crew leaders, camp managers and camp owners in assuming responsibility for cleanliness of their respective areas, with varying degrees of success. On the other hand, discovery of 13 camps not permitted by the Building Department or the Health Department, all substandard, constituted progress in reverse. As a result of our presentation to the Board of County Commissioners, a committee, chaired by the county agricultural agent and including the health department, building department and growers is scheduled to convene in the near future to insure compliance in future with county and state building and sanitary codes. Preliminary informal discussions on the subject give rise to guarded optimism.

Enlightened self-interest on the part of a few growers resulted in well constructed and operated labor camps. As was to be expected, these particular growerd did not experience the acute shortages of field labor so prevalent in other areas of the county.

As in the past, physicians cooperated wholeheartedly with the project and many donated their professional services.

Pharmacists continued to provide drugs at welfare rates.

The Naples Community Hospital admitted 573 workers and dependents for a total of 2,483 hospital days. Priced at the current per diem rate of $37.99 for hospitalization of the indigent, the donation to the project totals $94,329.17.

As covered in another section, a significant contribution to the dental health of migrant children was made by the Collier County Health Department.

As in prior years many agencies and clinics in the Miami area provided services at no cost to the project or patients. Value of these services is estimated at $30,000.

Collier County Cancer Society donated $1,200 to defray operating costs of the bus used in transporting patients to clinics. During the 17 months the bus has been in operation, the bus has clocked over 67,000 miles.

The major accomplishment during the reporting period was provision of definitive medical care for ill and injured migrants with consequent reduction in morbidity and mortality. Lesser gains were made in environmental sanitation, and some progress in health education.

Major shortcoming was inadequacy of staff to accomplish the greatly expanded demand for services.

Project and non-project personnel of the Health Department collected all data for reporting purposes. This activity can be strenghtened by the addition of more personnel.

TABLE II

PATIENTS REFERRED TO CLINIC OUTSIDE THE AREA

National Children's Cardiac Hospital	2
Tuberculosis	8
Vocational Rehabilitation	44
Cancer	475
Crippled Children's Service	47
Council for the Blind	20
Anti-Convulsive Clinic	12
Total.................	608

ETHNIC GROUP

White	265
Negro	218
Spanish	125
Total.................	608

AGE GROUP

Up to 16 years of age	72
Adults over 16 years	536
Total.................	608

TABLE III

REPORT FROM THE DENTAL CLINIC ON THE WORK PERFORMED ON MIGRANT CHILDREN (WHITE AND COLORED) FROM JULY 6, 1965 - JUNE 8, 1966 AGES: 6 - 12

	NEGRO	WHITE AND MEXICAN
JULY, 1965	4	8
AUGUST, 1965	8	9
SEPTEMBER, 1965	0	13
OCTOBER, 1965	1	48
NOVEMBER, 1965	99	0
DECEMBER, 1965	13	36
JANUARY, 1966	0	57
FEBRUARY, 1966	0	28
MARCH, 1966	1	93
APRIL, 1966	77	7
MAY, 1966	84	0
JUNE, 1966	8	1
TOTAL	295	300

GRANT TOTAL: 595

TABLE IV

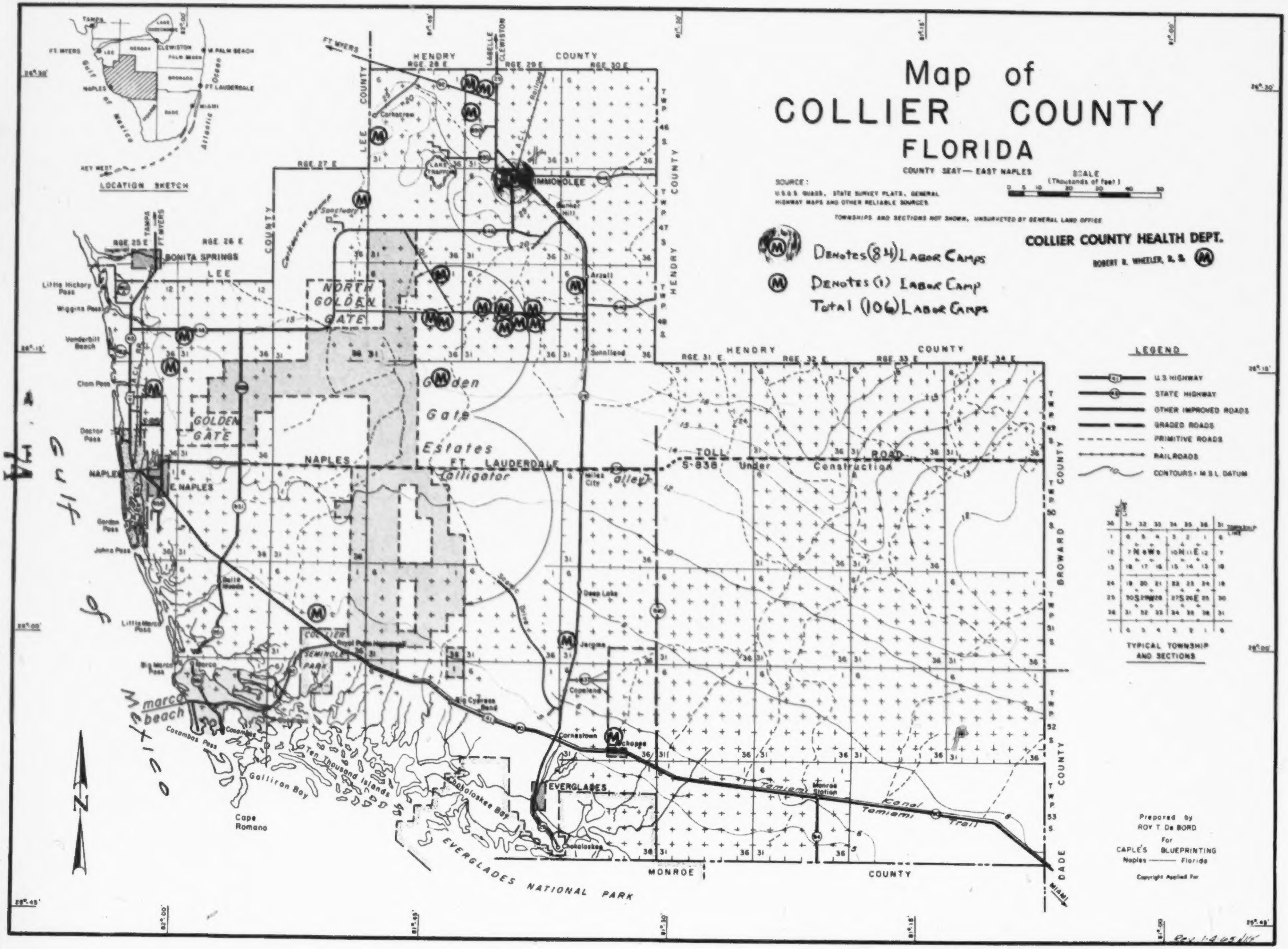
OTHER SERVICES PROVIDED

MATERNITY SERVICE:	MIGRANT TOTAL	COUNT TOTAL
Medical Conference	457	574
Nurses Office Conference	725	925
Nurses Field Visits	171	292
Family Planning	268	410

BIRTHS:	MIGRANTS	COUNTY
	167	488

HOSPITAL DELIVERIES:	WHITE	MEXICAN	NEGRO	INDIAN	TOTAL
	23	56	25	3	107
MIDWIFE DELIVERIES:	9	15	33	3	60
TOTAL	32	71	58	6	167
BY AGE: 15 to 20 yrs.	11	36	34	2	83
20 to 40 yrs.	21	35	24	4	84
TOTAL	32	71	58	6	167

CHILD HEALTH:	0/1	1/4	5/+	Total	0/1	1/4	5/+	Total
		MIGRANTS				AGE GROUP		
Well Child Conf.	52	18	18	88	98	36	30	164
Nurses Office Visits	334	352	339	1025	414	431	470	1315
Nurses Home Vi.	82	40	48	170	135	89	165	389
TOTAL	468	410	405	1283	647	556	665	1868


Map of
COLLIER COUNTY
FLORIDA
COUNTY SEAT — EAST NAPLES
SOURCE:
U.S.G.S. QUADS, STATE SURVEY PLATS, GENERAL HIGHWAY MAPS AND OTHER RELIABLE SOURCES
SCALE (Thousands of feet)
0 5 10 20 30 40 50
TOWNSHIPS AND SECTIONS NOT SHOWN, UNSURVEYED BY GENERAL LAND OFFICE
COLLIER COUNTY HEALTH DEPT.
ROBERT R. WHEELER, R. S.
Denotes (84) Labor Camps
Denotes (1) Labor Camp
Total (106) Labor Camps
LEGEND
U.S HIGHWAY
STATE HIGHWAY
OTHER IMPROVED ROADS
GRADED ROADS
PRIMITIVE ROADS
RAILROADS
CONTOURS: M.S.L. DATUM
TYPICAL TOWNSHIP AND SECTIONS
Prepared by
ROY T De BORD
For
CAPLE'S BLUEPRINTING
Naples —— Florida
Copyright Applied For
LOCATION SKETCH
TAMPA
FT. MYERS
CLEWISTON
W. PALM BEACH
FT. LAUDERDALE
MIAMI
NAPLES
KEY WEST
Gulf of Mexico
Atlantic Ocean
HENDRY COUNTY
LEE COUNTY
BROWARD COUNTY
DADE COUNTY
MONROE COUNTY
RGE 25 E
RGE 26 E
RGE 27 E
RGE 28 E
RGE 29 E
RGE 30 E
RGE 31 E
RGE 32 E
RGE 33 E
RGE 34 E
TWP 46 S
TWP 47 S
TWP 48 S
TWP 49 S
TWP 50 S
TWP 51 S
TWP 52 S
TWP 53 S
FT MYERS
LABELLE
CLEWISTON
TAMPA
MIAMI
IMMOKALEE
Corkscrew
Lake Trafford
Sunniland
Arzell
Bonita Springs
Little Hickory Pass
Wiggins Pass
Vanderbilt Beach
Clam Pass
Doctor Pass
NAPLES
E. NAPLES
Gordon Pass
Johns Pass
Little Marco Pass
Big Marco Pass
Marco
Caxambas
Caxambas Pass
Cape Romano
Gulliran Bay
Ten Thousand Islands
Chokoloskee Bay
Chokoloskee
EVERGLADES
EVERGLADES NATIONAL PARK
NORTH GOLDEN GATE
GOLDEN GATE
Golden Gate Estates
Corkscrew Sanctuary
COLLIER SEMINOLE PARK
Deep Lake
Jerome
Copeland
Carnestown
Ochopee
Monroe Station
Big Cypress Bend
Tamiami Trail
Tamiami Canal
Naples Ft. Lauderdale Toll Road S-838 Under Construction
Alligator Alley
Scenic Drive
ACL Railroad
Marco Beach
Gulf of Mexico
Rev. 1-4-65 [illegible]

GLADES, HENDRY & HIGHLANDS COUNTY HEALTH DEPARTMENTS

William F. Hill, Jr., M. D., Director

Glades and Hendry Counties:

Area of Glades County: 746 square miles

Resident Population: 3,200

Area of Hendry County: 1,187 square miles

Resident Population: 10,600

Number of Migrants (combined): 8,000

Highlands County:

Area of County: 1,041 square miles

Resident Population: 22,000

Number of Migrants: 3,000

Migrant Project Staff (combined):
- 2 Public Health Nurses
- 1 Sanitarian
- 1 Clinic Physician (Part-Time)
- 1 Clerk-Typist

MIGRANT HEALTH SERVICES PROJECT REPORT

HENDRY - GLADES COUNTIES, FLORIDA

(May 1, 1965 - April 30, 1966)

Migrant agriculture workers in Hendry and Glades counties are awakening to the importance of health measures. This year all personnel concerned with the Migrant Health Project have noticed a greater ease in dealing with migrants, a more ready acceptance of efforts to keep them well, and an increased responsibility in health matters.

Chief problems continue to be housing and sanitation. The first Annual Progress Report, covering the period September 1, 1964 to May 20, 1965; set forth the many difficulties encountered in reaching goals set in project objectives:

The principal difficulties were:

(1) Location and identification of migrant workers.
(2) Lack of personnel.
(3) Lack of physical facilities for health care.
(4) Language barriers.
(5) Wide spread distribution of workers in thinly populated areas.
(6) Poor communications with growers and farm managers.
(7) Apathy on part of permanent population.
(8) Inadequate housing.
(9) Inadequate water supply
(10) Inadequate facilities for disposal of human and household waste.
(11) Lack of funds for hospitalization of migrants.

This, the second Annual Progress Report, covers the period May 1, 1965 through April 30, 1966; and records efforts made to overcome these difficulties and approach more nearly the accomplishment of the project objectives.

The project objectives are:

(1) Improve environmental health aspects of migrants' existance by stricter enforcement of camp regulations; encouragement of growers to provide field sanitation services.

(2) Extend health education to migrant adults.

(3) Compile information on migrant population through use of liaison workers.

(4) Education of public about project's aims.

(5) Extend medical care in project counties through employment of staff physician; referral to private doctors; employment of physician on a fee basis.

DOMESTIC AGRICULTURE MIGRANT WORKER SITUATION IN GLADES AND HENDRY COUNTIES

Migrants in Glades and Hendry counties in previous years lived mostly in camps. A conspicuous shift of the workers to cities and to individual living quarters along the highways and out in the fields has taken place. Closure of some of the labor camps because of failure to come up to standards resulted in the moving of many workers to urban or other rural facilities that were even more deplorable than the ones they were driven out of.

A large segment of the agriculture workers, those engaged in sugar production, are from British West Indies. They live in housing provided by the sugar mills. Their health requirements are mostly taken care of by contract physicians. When needed, local public health facilities were available to them.

The total migrant agriculture population included Negroes, Texas-Mexicans, Anglos, Indians; in addition to sugar cane workers from British West Indies. While the ethnic groups tend to remain separate from one another so far as living arrangements, the fields and groves often presented a well diversified mixture of social backgrounds.

On one occasion when a case of hepatitis in a citrus worker brought 20 contacts to the health department for protective injections of gamma globulin - North Carolina, Indians, Texas-Mexicans, Negroes from Alabama and Anglos from Georgia were seen.

The workers, so far as their migration habits are concerned, may be divided into several groups:

(1) "Stable" migrants. These people reside in camps or towns in Florida from September or October to late May or early June. They follow a relatively stable pattern of movement up the East Atlantic coast and return to their Florida farms. They usually go to the same areas each summer. Some go up the Atlantic Coast, many go to Wisconsin or Michigan, then to Indiana or Ohio, then by way of Texas (Tex-Mex) back to Florida.

(2) "Semi-permanent." These move about in Florida according to demand for workers; staying a few days or at most a week or so in one area. They usually have a permanent home (or one they call permanent) somewhere in Florida, which may change every few years. Many of them engage in "day haul" activity that may take them up to 100 miles from their homes. During the summer they move up the Atlantic coast or to North Central United States. During their winter stay in Florida they can be considered as "shortterm" migrants.

(3) Floaters. These are the workers who work a few days in one area then are gone. Many of these are drifters - nomads - by personality structure. These are the unfortunates, the ones who give the stigma that often is attached to the migrant population. Their problems are many and often defy definition.

An accurate census of the migrant population would be most helpful, but

77

probably would require the combined efforts of several persons.

We get a fairly accurate estimate of the number of residents in the labor camps, but the person who lives in the towns and along the highways, eludes enumeration. One can gain only a rough approximation from what can be seen by driving along the highway and through the streets of the cities and towns.

We sought the aid of Vista workers and were able to get two of them towards the end of the year - In May. They reported no success in encompassing the problems of census. They said: "These people are scattered all over and are hard to find." Their report is attached.

It is hoped that some sort of registration procedure can be found by means of which identification and location of the migrant worker can be accomplished.

The turnover - the impermanence - of these people is astonishing; not even their neighbors know about them - or if they do are reluctant to give information.

The day haul workers, which at the peak of the season make up the majority of the workers, have not been counted. An impression can be gained by noting the number of buses on the highway in the early morning or late afternoon and trying to read the names painted in crude letters on the sides of the vehicles. The peak population in our area is in May - when the vegetable crops are being harvested.

LOCATION AND IDENTIFICATION

The activities of nurses resulted in discovery of living quarters that actually came under the classification of labor camps since they housed more than 15 persons. These were substandard, were not licensed and could not be licensed in their present condition. Some of these were within city limits; other, outside.

In one of these Boarding Houses (Slim Mabray's), three cases of tuberculosis was found. Nineteen single men lived in this house. They traveled 30 or more miles by day haul bus to the fields where they worked.

Becuase of inadequate housing in adjacent Collier County, Glades and Hendry experienced an influx of migrants looking for housing.

When housing regulations are more stringently applied, workers migrate to areas of less stringent application where they stay until the pressures again mount. This points up the need for coordination of efforts and uniformity of application of the regulations.

A census was taken by nurses of the shanty town housing that developed along Highway 29 south of LaBelle and along Highway 833 south of Highway 80:

CENSUS BY NURSES

Highway 29 - Five mile stretch south of LaBelle

Trailers	32 (Few provided with septic tanks)

Busses	2
Houses (frame)	5 (1 unpainted)
Cabins	4
Shacks	18
Outhouses	2 (for this entire group of dwellings)

Inhabitants report they use the woods for disposal of waste; Both human and kitchen.

Highway 833 (Devil's Garden Road) - 3 mile stretch

Trailers	5
Shacks	7
Houses (CBS)	2
(Frame)	1
Outhouses	1 (in tomato field)

MIGRANT LABOR IN HENDRY COUNTY - Prepared by Vista Workers:

LABELLE QUARTERS:

LaBelle has a fairly sizeable and stable colored neighborhood. Many of its residents have lived here 20 or more years. The seasonal workers are scattered throughout this community with no apparent tendency to remain apart from permanent residents. Some persons who spoke of camps near LaBelle did not know their location.

The gathering point for migrant workers is the corner in front of "Juke Joint;" run by Junior Dozier. Busses and trucks stop here to load up. Some busses come partly loaded from other gathering points. From Junior Dozier, who was very helpful and from others we have learned that during the peak working periods migrant workers in this area total 300.

Most of these workers do not leave the state. They move northward by short hops as the crops progressively become ready for harvesting. Some will migrate to Georgia, the Carolinas and other Atlantic Coast states. Others move to Pennsylvania, Michigan and other northern states. Most of the traveling workers remain in the immediate LaBelle area, about four months in each year.

South of LaBelle, just south of Spencer's Market are about 16 households of seasonal farm workers. Three families were Puerto Ricans, the others were Mexicans. Their shacks and cabins were interspersed among those occupied by the permanent white citizenry.

WILLIS CAMP:

Willis Camp, owned by the Campbell Company, is on the south side of Highway 846, about 13 miles east of Immokalee. It is in the worst condition of the major camps we visited. There are 16 duplex barracks-type units and eight 15 x 15 units, 1 restaurant and bar combination, only one house has indoor plumbing. The total number of dwellings is 26; 75 to 100 people live there at the peak of the season. All of the people there were Mexican, and had come from Homestead or from Delray, Florida.

The people at Willis Camp did not know about the clinics held at S & M Camp and were pleased to find out about them. None of the children attended school because no school bus comes by the camp.

S & M CAMP:

The S & M Camp, houses about 100 to 120 Mexicans. Most every one in this camp knows of the clinic or they have their own personal physician. From here they will move to Michigan on the 12th of June. Three or four families stay year around.

6 L's CAMP:

The 6 L's Camp is on the north side of highway 846, about 20 miles east of Immokalee, has 20 dwellings; including some tin buildings, some new wooden ones, a few trailers and a bus that a man and his wife fixed up to live in. One crew had already left for Texas, others left June 21. Francisco, who lives in a trailer in the back of the camp, will stay here all year. During part of the summer he will help the 6 L's fix up the camp. They are going to remove the tin buildings and put up more wooden ones. The camp will be larger next year. He said workers do not pay rent in the camp. During the summer the ranch brings meat (beef - hogs) for the people to eat.

Some of the people were not familiar with the services offered by the health clinics. They did not know how to get medical help.

CLEWISTON HARLEM QUARTERS:

Most of the migrant population of Clewiston is centralized in the area known as Harlem. This area includes from 8 to 10 large blocks. The major streets are Georgia, Tennessee, Alabama, Florida and Lemon Grass. This area is entirely outside the city limits of Clewiston. The houses range from very middle class to poor in nature.

While the majority of Harlem's residents are year round employees of the U.S. Sugar Corporation, some travel up stream along the Atlantic coastline and others go to Michigan and other northern states.

Vistas could be of great help in Hendry County by assisting the county in some of the areas where migrants stay; by teaching proper sanitation and housekeeping methods and by helping teach literacy courses and other English classes.

FUTURE TRENDS IN MIGRANT AGRICULTURE EMPLOYMENT IN HENDRY COUNTY

Migrant labor forces needed during peak months in 1975 will number more than 10,000. Problems now evident will increase.

Present labor needs in agriculture are fairly well taken care of by those who reside in the county and by those who commute from adjacent counties. While some of these follow the migrant stream, they call this general area their home.

With the great strides in citrus planting, the vegetable industry with its stoop labor, is most likely to suffer for labor by 1975. If mechanical

80

harvesting for citrus crops has not been developed in a significant way, citrus harvesting demand for workers will deplete the labor pool now available for the vegetable industry. Another factor is education. Our youth are remaining in school longer and the number willing to accept agricultrual employment will no doubt decrease. Education will have a very decided effect on the migrant stream as well.

The lack of adequate housing might become the foremost problem for agriculture in future years. Housing has failed to keep pace in other areas in similar situations.

The 2% to 3% annual decrease in migrants may exceed 6% to 7% by 1975. Growers do not expect a great change in the number of people available for farm work in this area from the citizen supply. The difference will have to be made up from the migrant population.

This will bring into even sharper focus the welfare of the migrant. Local citizens, governmental agencies and churches must become increasingly aware of their part in the migrant program.

Since county zoning will become a necessity, the officials will recognize the problems involved in setting up a uniform building code for the entire county and in controlling sales of unrecorded subdivisions. Their attention is being directed to the location and adequacy of migrant housing. Serious consideration is being given to the relative advantages of construction in cities where adequate water and sewage facilities are available; or of development of these facilities in non-urban areas. Employers will be encouraged to provide housing on their own properties.

Other counties have found that zoning will help insure that county growth will be systematic and orderly. Our county commissioners have authorized a study to determine the exact type of bill to be requested of the state legislature granting them the necessary authority.

NOTE: The information contained in this section was obtained from "Hendry County Development of Agricultural Resources Engineering 1965-75" Prepared by the County Agriculture Agent's Office.

SEASONAL WORKERS NEEDED BY 1975
(In Agricultural Production and Harvesting)

Seasonal Workers	Citrus	Vegetables	Sugarcane	Animal Industry
July	2,835	212	192	
August	2,570	205	144	
September	2,300	300	144	
October	3,000	565	192	
November	4,000	1,192	696	
December	6,800	1,449	840	
January	8,100	1,707	840	
February	8,150	1,592	600	
March	5,320	1,789	576	
April	5,400	2,346	432	
May	6,660	2,286	384	
June	5,140	906		
Year 'round	1,929	787	342	1,434

SERVICES PROVIDED

FAMILY HEALTH SERVICES CLINICS

The following six clinics were staffed and operated:

CLINIC I

Location: Hendry County - Clewiston

Facilities: At Hendry General Hospital - Porch at end of one of the wings; a few feet of the adjacent hallway, and one small patient's room converted to clinic use. (After August 1, 1966 this will be carried on in the new Health Department building.)

When: Each Monday - 9:30 to 11:30 A.M.

Type of Services: Prenatal; family planning

Staff: One clerk, two public health nurses, one physician

CLINIC II

Location: As above

Facilities: As above

When: Each Monday - 1:00 to 3:00 P.M.

Type of Services: A family health service clinic was held at the same location as Clinic I, with same facilities and staff with an additional second clerk.

CLINIC III

Location: S & M Labor Camp - 35 miles south of Clewiston, Hendry County.

Facilities: One room struction, 8 x 13 feet. During the year this building was improved by the installation of electrical wiring, connecting to water supply; installation of supplies; addition of furniture and equipment.

When: Each Tuesday, 5:00 to 8:00 P.M.

Type of Services: Family Health

Staff: One public health nurse, one physician

CLINIC IV

Each Tuesday - 1:00 P.M. to 3:00 P.M. for immunizations, health education, prenatal care. At same location as Clinic III, staffed by Public Health Nurse alone.

CLINIC V

Location: Moore Haven - Glades County Health Department in Glades Courthouse

When: Each Thursday - 10:00 to 11:30 A.M.

Type of Services: Family Health

Staff: One clerk, two public health nurses, one physician

CLINIC VI

Location: LaBelle - Hendry County Health Department building

When: Each Thursday - 1:00 to 3:00 P.M.

Type of Services: Family Health

Staff: Three clerks, two public health nurses, one physician

In 1965 additional clinics were held as follows:

> In May - at a tent camp on Highway 29, outdoor family clinics were held off card tables and tailgates of autos each Wednesday from 9:00 to 11:00 A.M., staffed by Public Health Nurse and clerk. The physician made one visit, the rest of the time transportation was provided for patients needing doctor's care to Thursday afternoon clinics at the Health Department in LaBelle, or to private doctors in Clewiston or LaBelle.

During May, June and July (1965) family health clinics at S & M Labor Camp #3, in the small camp clinic building each Friday - 9:00 to 11:00 A.M. - staffed by Public Health Nurse and by M.D. (once).

The work accomplished at these clinics is detailed in Tables I to VIII. A total of 258 clinic sessions were held (Table I), representing the expenditure of 774 hours by each of the staff members in attendance. Of the 1,232 patient visits (Tables II & III), 748 were handled by the nurse alone, 484 by the doctor. In eight months of 1965 the number of patients visits was 413, averaging about 50 per month. In 1966, after adequate staffing for the project became available, the number rose to 822, in the four months an average of 205 per month.

The preponderance of visits (Table IV) of persons under 15 years of age is a reflection of the immunizations carried out. Otherwise, most of the patients were in the 15 to 44 age bracket.

The problems encountered (Table V) were mostly upper respiratory infections, check-ups for maternity cases and well-baby examinations. The unusually large number included in tuberculosis involved tracking down and checking out contacts of the six patients with tuberculosis that were found among the migrant workers.

Only 16 persons (Table VI) presented health cards; 270 were issued new ones at our clinics.

Local referrals to health facilities in Florida (Tabel VII) was 69. The number of referrals is surprisingly small considering the number of persons who passed through the clinics. However, the maternity patients, referred to private doctors, are not included in this number. Also, many migrants who needed medical care proceeded on their own to get it. Furthermore, many more referrals would have been made if the mechanisms for referrals and the facilities had been available. Many of the patients needing elective surgery (e.g., gallstones and tumors) did not get the care because of lack of funds for hospital expenses; to pay a thoracic surgeon; and because ophthalmolgists had no open appointments for three or four months. In some instances referrals to ophthalmologists could have been obtained, but the patients was originally routed through the Florida Council for the Blind with attendant delays, and by the time the decision was made to send the patient to a private physician, the time had come to migrate. In other instances patients had exanthemata or respiratory infections on the day of appointment. . . Many just did not show up.

Referrals to other health departments. Up to the end of April (1966) only five persons were referred to other health department. In 1965, a total of 33 such referrals were made.

In 1966 Hendry County participated in the referral evaluation project aimed at helping migrants locate health centers and thus be able to continue their care after leaving this area. Since most of the workers left after April 30, information about the success of this project is not now available. After the close of the period covered by this report 101 referrals were made to other health departments.

Table VIII presents further information about health activities. Some of this data is covered in other tables. It is included here the way it appears in routine health department activity reports.

Summary and Conclusions: Of the five project objectives we feel we accomplished one to a very significant degree: Medical care was extended by employment of a staff physician and by more referrals to private doctors. The comparative tables of 1965 and 1966 activities reflect this.

Some progress was made in the matter of housing and sanitation but much more needs to be done. Our relations with growers and managers were quite satisfactory.

Liaison workers (Vista workers) were used to a limited degree at the close of the season.

Health educational efforts for adults were made but the broader and more basic problem of general education for adults was only lightly touched upon. Last year's experience with a health educator, whose efforts were spread over four counties, taught us that with so much territory to cover an effective program did not develop. As a consequence, this year the use of a health educator was not considered feasible and accordingly, education was carried out by doctors and nurses.

TABLE I

FAMILY HEALTH SERVICE CLINICS - NUMBER HELD

1965	
May	24
June	22
July	23
August	18
September	18
October	16
November	18
December	18
Total	157

1966	
January	26
February	24
March	27
April	24
Total	101

Total for year	258
Total number of hours	774

TABLE II

NUMBER OF PATIENT-VISITS

	1965 - 8 Months May 1 - Dec. 31	1966 - 4 Months Jan 1 - April 30	Totals for Year
NURSE:	262	486	748
DOCTOR:	151	336	484
TOTALS:	413 (av. 50/mo.)	822 (av. 205/mo)	1232

TABLE III

PATIENTS SEEN - BY CLINICS

				LABOR CAMPS			
	Clewiston	LaBelle	Moore Haven	1965	1966	Total	TOTAL
NURSE:	17	50	88	262	331	593	748
DOCTOR:	5	45	38	151	245	396	484
TOTALS:	22	95	126	413	576	989	1232

TABLE IV

AGE/SEX DISTRIBUTION
(1966 Only)

	Under 15	15 to 44	45 and Over	Total
MALE:	220	91	10	321
FEMALE:	240	251	10	501
TOTALS:	460	342	20	822

TABLE V

CLINIC PROBLEMS

Allergy	3
Gastro Intestinal	33
Upper Resp. Infection	103
G. U.	4
Tumor	2
E.Ent.	16
Infant Check	134
Dermatology	12
Dental	54
V.D.	20
Maternity	153
Cardio-Vascular	14
Orthopedic	8
Tuberculosis	51
Family Spacing	64
Gynecology	6
Trauma	52
Neuro-Psych.	18
Contagious	22
Intestinal Parasites	15
Miscellaneous	56
Total	1,232

TABLE VI

PATIENT HEALTH RECORDS

(Immunization cards, Maternity Cards)

	Patients Who Presented Cards	New Cards Started
S & M #3	10	70
LaBelle	1	155
Moore Haven	5	45
Total	16	270

TABLE VII

LOCAL REFERRALS

	1966
Hospital	3
Private Doctor	36
Tbc. San.	6
Florida Council for the Blind	5
Dentist	14
Tumor Clinic	1
Voc. Rehabilitation	2
Mental Health	2
Total	69

TABLE VIII

ADDITIONAL DATA

FROM ROUTINE HEALTH DEPT. ACTIVITIES REPORTS

	Visits	Office	Other Activities
A. Communicable Disease			
Immunizations Completed			407
Boosters & Revaccinations			125
Treatment for Parasites			21
B. Venereal Disease			
New Cases	3	9	
C. Tuberculosis	170	67	
Active Cases			6
Suspects Processed			58
Tuberculin Tests			24
Patients Hospitalized			5
X-Rays, 14 x 17			51
D. Maternity	32	133	
Patients			51
Attendance at Pl. Parent. Clas.			99
E. Child Health	55	201	
F. School Health (No. Examined)			20
Nurse - Teacher Conferences			10
G. Dental			
(Examins. at S & M Camp)			31
H. Chronic Diseases			
Cancer	1	3	
Diabetes	3	1	
Cardio-Vascular	1	5	
Vaginal Cytology			14
Other	63	12	
J. Mental Health	3	2	
Miscellaneous	34	156	

V. Health Education (Sessions attended, talks given)

Doctor - 11 Nurse - 36 Sanitarian - 41

X. Laboratory	Serology	47	G.C.	2	Urin.	126
	RH	26	Gluc.	5	Abscess culture	1
	Dextro-stix	28				

MIGRANT HEALTH - NUTRITION

GLADES AND HENDRY COUNTIES

September 1965 - May 1966

Tours were made of migrant camps to acquaint the nutritionist with the various types of camp facilities.

It was noted that most migrants provide their own cooking equipment.

With the aim of improving the migrants' nutrition by supplementing his cultural pattern of eating, a series of outdoor demonstrations were planned.

It was decided to conduct these demonstrations at the S & M Mexican migrant camp in Hendry County during the evening clinic hours.

Pre-demonstration activities included the establishment of rapport with the migrants, the printing of posters and announcements and the trial-run of the demonstration.

Rapport was established with the children by talking to them about the basic four food groups with the understanding that they were teaching the nutritionist Spanish words, singing songs about food, etc., while the physician and nurse held adult clinic.

News of the demonstration was announced by a poster and by the nurse in clinic or on home visits.

The trial run was necessary to insure all material needed were at hand.

The first demonstration was that of using powdered mild. The milk was reconstituted in sight, heated on a camp stove, flavored with cocoa mix or instant coffee, then served.

The children were very eager to observe and sample, however, the adults stood at a distance to observe and very few sampled. Apparently this adult behavior is typical when anything new comes to the camp.

Another demonstration was planned in hopes of reaching the adults. This was never conducted, due to rain and illness.

Problems encountered in the outdoor demonstrations were rain and darkness.

The demonstrations were postponed several times because of rain. Darkness was overcome by the use of a single light; however, working conditions were still poor.

Several films were previewed by the nutritionist and the nutrition coordinator for migrants. A few were found to be usable in programs for the migrants.

One weight-reduction instruction was given to a female patient during a day clinic. The nurse did a follow-up and learned that the woman felt she could not stay on it.

A teenager wanted to know what foods to eat that would give her shapely calves.

A committee has been formed by the Division of Nutrition to plan nutrition services for migrants. Notes from the two meetings held thus far are attached. The plans made by this committee will be the basis for programs in the future.

Record keeping of hours spent by a nutritionist on work related to migrant health was begun in February, 1966. From February through May, 1966 a total of 37 hours has been devoted to migrant health in Glades and Hendry Counties and 22 hours have been devoted to program planning for the state.

MIGRANT HEALTH PROJECT

Objectives:

(1) To get all personnel working with migrants cognizant of "good" food use (practices) and not to impose their own values on the migrants.

(2) To work with other personnel to help migrants improve food use.

(3) To help personnel understand the values of migrants - need to ask migrants their values of food.

(4) To provide experiences which will motivate migrants to improve their eating habits.

Discussion:

The overall program inclues:

Clinics - Health Department
Mobile
Private Physician
PHN
Dentists and assistants
Sanitarians
Nutritionists
Clerk
Health Educators
Social Workers
Vista
Extension Service Agents

Needs:

Comprehensive medical care (in some counties this is met by private physicians who charge a small fee)

Problem Areas:

Health Education

Nutrition Education and food sanitation
Limited Education of migrants creates difficulty in communication
Lack of communication because of language and culture

Suggestions:

(1) Meet with the nutritionists from Texas and California

(2) Find out visual aids available in other states to see what is available, then make more

(3) To implement nutrition education by:

A. Working with:

1. Leaders in small groups
2. PHN, Sanitarians, Health Educators

B. Including home economics extension agents in on the planning stage

Committee Meeting - Belle Glade (April 5-6, 1966)

In Attendance - Mildred Kaufman
G. Floyd Baker
Grace Brown
Myra Blanchard
Bill Clarke

Notes:

Purpose: To improve the nutritional status of agricultural migrants in the State of Florida.

Objectives: (1) To identify the nutritional problems of agricultural migrant workers. Examples:
- A. Nutritional anemias
- B. Pregnancy difficulties due to poor nutrition
- C. Diarrhea

(2) To identify the food habits of the agricultural migrant workers.
- A. What foods are eaten
- B. When foods are eaten
- C. Where foods are eaten
- D. How foods are eaten
    - 1. Raw
    - 2. Cooked

(3) To develop an educational program to meet the nutritional and dietary needs of the agricultural migrant and his family.
- A. To conduct inservice education programs for:
    - 1. Nutritionists

2. Public Health Nurses
3. Sanitarians
4. Physicians
5. Community Health Workers
6. Teachers
7. Lunchroom personnel dealing with migrants.

B. To provide some direct diet counselling and nutrition education to migrants.
   1. Individual
   2. Family
   3. Group

C. To provide consultation on menu planning and food service to managers and employees of Day Care Centers for migrant children.

Other thoughts: Do we need to include items on school lunch, teachers, etc., as part of the educational program?

Development of materials: Audiovisuals, pamphlets, slides, food models, posters

SANITARIAN'S REPORT

The one sanitarian is a full-time employee for the migrant project in both Hendry and Glades counties. A survey of the migrant population is important for this area but was not accomplished this past season because the expected Vista workers were not available. It will be completed this coming season.

The Laws and Regulations for these migrant camps are covered in the Florida State Board of Health Rules under Section 170C-32. The definition of a camp is cited in 170C-32.02.

Methods of obtaining corrections is in most cases education and good working relations with growers and supervisors. Occasinally letters of warning are necessary to assure corrections. Many failures to comply with regulations are due to misunderstanding and to grower's and supervisor's preoccupation with the crops during the growing season. Another difficulty in getting the needed improvements is the reluctance of building contractors to work in remote parts of the county. Some migrant housing in towns has already been condemned.

Because much of the land on which the growers farm is leased, the grower hesitates to put up adequate living quarters. Some growers picture ghost towns of these new constructions in the future. We find better housing where the grower himself owns the land. Many growers prefer to put up concrete block structures but because of the uncertainty of future operations on leased land they build temporary plywood housing.

The people living in the communities accept the migrants presence and are quickly coming to realize that better housing for them is necessary.

In fact and in deed because of the poor housing in the migrant camps or becuase of the long growning season in Florida, migrants have a desire to own their own property and houses. As a result crudely unstable housing, insanitary sewerage disposal and water supplies are being placed on a small lot. These small lots are located mainly on one of the major highways in the LaBelle area. They present not only eye sores but health hazards as well. The sanitary conditions of this area are being brought up to minimum requirements.

Not much improvement has been noted in the efforts of migrants themselves to take care of facilities provided them. For example: In one of the camps twelve new approved privies were constructed and in less than three weeks screens were knocked out, seats torn off and other types of destruction involved about half of them. Certainly education would help considerably but it is not expected to be the total answer to such problems.

Classes and conferences are important to promote a better understanding between the health department and growers. Many problems which concern water, sewage, housing and sanitation that growers do not understand can be discussed. This will benefit both parties and build greater relations. For instance, a grower received a water sample report which he really doesn't understand; A -1 or 30+ means very little or nothing at all to him.

Individuals have been given personal instruction by the sanitarian in the operation of chlorinators; how to recharge them and keep them operative. Individual instruction however is very time consuming - much more can be accomplished if group demonstrations are held.

Some interest has been created in the area of new housing. Regretfully a major housing plan was abandoned by the Campbell and Gaunt concern. Another grower, and incidentally one who owns his own land, will soon begin construction of new housing for his laborers. This will be a pilot project for this area and hopefully will be a stepping stone for future construction. However the grower is in the citrus industry where labor is not an acute problem at present.

The old motel in the "quarters" in LaBelle has been condemned and is being torn down.

The migrant sanitarian completed a 12-week inservice training course which greatly increased his understanding of sanitation for migrants. He approaches problems with renewed interest and anticipation of a more productive year.

A greater effort must be made to have camps completely restored for operation before migrants return the next season.

The off-shore labor continued to be the better source of help in the eyes of the growers, particularly in sugar cane. From the sanitarians view point, also, they are a better group to work with. They maintain housing as it should be. There is not as much drunkenness or deliquency among these as among native migrants.

Hot meals are delivered to most of the workers in the fields at noon, with a remarkable degree of efficiency and skill in food handling. Sanitary facilities in the fields continue to be a problem although the situation has improved over last year.

There are some insanitary practices on the part of the grower in leaving spoiled fruits and vegetables in the field and at grading stations. This is a problem chiefly with watermelons which not only causes an odor problem but also prives food for rodents and places for fly breeding.

In Hendry and Glades counties the raising and processing of agricultural products is an established industry and one that will continue to expand. Public officials, health workers, growers, owners, managers, must all recognize the responsibilities this involves so far as the labor force is concerned. The workers and their families must have satisfactory housing and sanitation if the industry is to survive.

The camps have or can be provided with adequate sanitary facilities and the growers are willing to supply them. But the people must be taught to use the facilities properly. The lack of knowledge about personal hygiene is appalling. Since the sanitarian's work is mainly with growers and their managers, the language barrier is not a problem but for the education of the workers and their families it does create difficulties.

SANITATION ACTIVITY

Service	
Public Water System	31
Private Water Plants	1
Public Sewerage System	2
New Specification Septic Tanks Installed	24
Mobile Home Parks	3
Camps	169
Complaints Investigated	10
Nuisances Corrected	2
Eating & Drinking Establishments	12
Private Premises	68

NOTE: The number of visits would have been considerably higher if the project sanitarian had not been attending the Sanitarian Training Course at the Florida State Board of Health for a three-month period during the "season."

MIGRANT HEALTH PROJECT
MG-18B R (66)

ANNUAL REPORT
HIGHLANDS COUNTY

There was only slight fluctuation in the number of migrants this season which began in mid-October and extended to July with the peak from December thru April. There were 1450 wage-and-salary workers in agriculture during the index month of March (See Chart #1). With a conservative estimate of three per family (six according to a Vista survey), there were approximately 3000 migrant workers and their families in Highlands County. The majority (75%) of these workers are residents of Highlands County, Florida and they migrate for three to four months each year. Their main pattern of migration is to the Carolinas, the Eastern Shore of New York State. The in-migrants generally come from the Southeastern United States (Georgia, Alabama, Louisiana and the Carolinas) with a few from New York State and Pennsylvania. There has been no change in the characteristics of these agricultural workers as they are predominately Negro.

The problem of identification still remains. As previously reported, the majority of these workers are residents of Highlands County and are assimilated in the general population.

There has been a great deal of support from the community for adult education, vocational training and day care centers thru the Vista migrant program. There are five Vista workers in the county. A copy of the preliminary survey in the Avon Park area is attached. (Chart #2). A day care center in Avon Park accommodating twenty-five children will open May 1, 1966. The Housing Authority of Avon Park has received approval for eighty low-cost housing units which will improve available housing. Other areas of the county are working on day care programs.

Citrus is an expanding industry in this area with new acreage yearly. Some diversification (see Chart #3) is planned through increased need for harvest labor and improvement of the present health programs.

(Charts #1, #2 and #3 follow this page)

MEDICAL AND NURSING

Highlands County has from 3000 to 4000 migrants who are residents of the county for eight months of the year. This past year the nursing staff has been attempting to identify these migrants living in the communities. We have found this rather difficult partly due to a limited number of nurses during this period; also, some families who had previously "gone North" were not planning to do so again this year. The out-of-state worker who comes into the county is often given medical care through arrangements made by his employer. Migrant families who are visited by Health Department personnel were encouraged to attend the Health Department clinics for the many services available to them. There are three general clinics held in Highlands County weekly. They are viz;

CHART #1

BASIC LABOR MARKET INFORMATION - HIGHLANDS COUNTY

		March 1959	March 1960	March 1961	March 1962	March 1963	March 1964	March 1965
1.	Total population	18,500	21,300	22,800	23,700	23,900	24,300	25,000
2.	Civilian labor force	6,050	6,200	6,250	7,200	7,150	7,400	7,450
3.	Total unemployment	200	150	250	200	200	300	200
	a. Unemployment rate	3.3%	2.4%	4.0%	2.8%	2.8%	4.1%	2.7%
4.	Total employment	5,850	6,050	6,000	7,000	6,950	7,100	7,250
5.	Nonagricultural employment	4,850	4,900	4,700	5,500	5,250	5,400	5,550
	a. Wage & salary workers	3,700	3,600	3,450	5,000	3,900	4,050	4,200
	Manufacturing	200	250	250	300	250	300	300
	Construction	250	350	300	300	250	300	350
	Transportation & Public Utilities	200	200	200	300	300	300	300
	Wholesale & Retail Trade	1,150	1,200	1,150	1,400	1,300	1,350	1,400
	Finance, Insurance & Real Estate	150	150	150	150	200	150	200
	Service	750	700	650	700	800	700	650
	Government	950	700	650	750	750	900	950
	Other Wage and Salary	50	50	100	100	50	50	50
	b. All other Nonagricultural	1,150	1,300	1,250	1,500	1,350	1,350	1,350
6.	Agricultural employment	1,000	1,150	1,300	1,500	1,700	1,700	1,700
	a. Self-employed & unpaid family workers	300	300	300	300	250	250	250
	b. Wage & Salary workers (Hired (Labor)	700	850	1,000	1,200	1,450	1,450	1,450

Research and Statistics Department
Florida Industrial Commission
Tallahassee
Florida

CHART #2

INITIAL SURVEY FINDINGS: AVON PARK AREA
January, 1966

U.S. VISTA and COMMUNITY ACTION FUND, INC.
MIGRANT PROGRAM: REGION #3

TOTAL NUMBER OF ADULTS SURVEYED------------------------------ 246
TOTAL NUMBER OF CHILDREN SURVEYED---------------------------- 485
GRANT TOTAL--- 731 persons

	NUMBER	PERCENTAGE OF ALL ADULTS
Average number of children in each family.	6	
Average age of adults when dropping out of school	13 years old	
Total number of adult drop-outs.	193	78%
Average adult educational level.	6th grade	
Number of adults engaged in farm labor	113	45½%
Number of unemployed adults	60	24%
Total number of Public Assistance Recipients	55	22%
Total number of eligible voters who are not registered.	95	39%
Number of adults requiring dental care.	98	40%
Number of adults requiring eye care.	25	10%
Number of adults requiring hearing attention.	4	2%
		PERCENTAGE OF ALL FARM LABORERS
Number of farm laborers contracting work in advance.	49	43%
Number of farm laborers migrating.	46	41%
SPECIAL INTERESTS:		PERCENTAGE OF ALL ADULTS
Number of adults interested in attending Literacy classes	110	45%

(Continued)

CHART #2 - CONTINUED

	NUMBER	PERCENTAGE OF ALL ADULTS
Number of adults interested in attending Home Management classes.	84	35%
Number of adults interested in attending Vocational Training classes.	104	42%

PUBLIC ASSISTANCE RECIPIENTS BREAKDOWN:

Benefit	Number of persons
Social Security	20
Old Age Assistance	9
Aid for Disabled	9
Workmen's Compensation	7
Aid for Dependent Children	6
Veteran's	4

MIGRATORY PATTERNS:

State	Number of persons
New York	27
Michigan	10
South Carolina	6
Delaware	1
Georgia	1
Virginia	1

CHILDREN:

	NUMBER	PERCENTAGE OF ALL CHILDREN
Total number of children in school	208	43%

NUMBER AND AGE OF CHILD IN EACH GRADE LEVEL:

GRADE	NUMBER	AGES
First	23	16 (6 year olds) 6 (7 year olds) 1 (8 year old)
Second	17	11 (7 year olds) 4 (8 year olds) 2 (9 year olds)

(Continued)

CHART #2 - CONTINUED

GRADE	NUMBER	AGES
Third	17	12 (8 year olds)
		4 (9 year olds)
		1 (10 year old)
Fourth	20	12 (9 year olds)
		4 (10 year olds)
		3 (11 year olds)
		1 (12 year old)
Fifth	33	23 (10 year olds)
		5 (11 year olds)
		4 (12 year olds)
		1 (13 year old)
Sixth	17	1 (10 year old)
		11 (11 year olds)
		3 (12 year olds)
		2 (13 year olds)
Seventh	16	6 (12 year olds)
		3 (13 year olds)
		5 (14 year olds)
		1 (15 year old)
		1 (16 year old)
Eighth	12	1 (12 year old)
		6 (13 year olds)
		1 (14 year old)
		4 (15 year olds)
Nineth	22	14 (14 year olds)
		6 (15 year olds)
		2 (16 year olds)
Tenth	16	2 (14 year olds)
		9 (15 year olds)
		3 (16 year olds)
		2 (17 year olds)
Eleventh	10	8 (16 year olds)
		1 (17 year old)
		1 (18 year old)
Twelfth	5	3 (17 year olds)
		1 (18 year old)
		1 (19 year old)

Total number migrating-------------------91

Percentage of all children-----------19%

Total of migrant children enrolling in schools in other states------------------54

Percentage of children who migrate----------------59%

(Continued)

CHART #2 - CONTINUED

MIGRANT CHILDREN ENROLLING IN OTHER STATES:

STATE	NUMBER
Michigan	18
Virginia	15
New York	10
South Carolina	6
Georgia	3
Delaware	2

Number of children, parents wish to send to a day care center--------114.

CHART #3 HIGHLANDS COUNTY'S AGRICULTURAL COMPLEX - 1965

CITRUS GROVES

30,000 Acres

NURSERIES (89)

Citrus	93.26 A
Ornamental	11.13 A
General	4.10 A
	108.49 A

DAIRIES

8 Farms
4,000 Dairy Cows

BEEF CATTLE

165 Owners
60,000 Cattle

VEGETABLES

1,200 Acres

POULTRY

4 Farms

FOOD PROCESSING PLANTS

3 Packing Houses

1 Processing Plant (Orange Juice)

MANUFACTURERS OF AG SUPPLIES

1 Fertilizer Plant

AG SUPPLIES AND SERVICES

41 Citrus Nurseries
5 Ag Equipment Dealers

2 A. Credit Agencies
8 Grove Caretaking Firms

FARM AND AGRIBUSINESS VALUES OF HIGHLAND'S AGRICULTURAL OUTPUT FOR 1965

	MILLIONS OF DOLLARS	
CROP	FARM VALUE	RETAIL
Citrus	29.5	89.4
Cattle and Calves	2.3	3.8
Milk	1.5	2.6
Ornamentals	1.5	4.0

(Continued)

CHART #3 - CONTINUED

	MILLIONS OF DOLLARS	
CROP	FARM VALUE	RETAIL
Vegetables	.3	.9
Poultry Products	.1	.3
Honey and Beeswax	.1	.3
Other	.2	.5
TOTAL	35.5	101.8

Sebring	Courthouse Annex 9:00 A.M. - 11:30 A.M.	Tuesday 1:00-4:00 P.M.
Avon Park	City Hall 9:00 - 11:30 A.M.	Wednesday
Lake Placid	Eide Building 1:30 - 3:00 P.M.	Wednesday

(See attached tables for data on immunizations for migrants and home and clinic visits to migrants.)

Each clinic session is attended by a physician, one nurse and a clerk. Any service offered by the Health Department is available to the migrants in the general clinics with the exception of chest x-rays. This service is given in the Sebring Clinic only. Referrals to Crippled Children's Commission, State Rehabilitation Services, Council for the Blind and to the Tumor Clinic can be made at these clinics. Since some of these agencies' headquarters are out of the county, we are faced with the difficulty of finding transportation for some of our patients. A local transportation committee would be a great help in the communities. We had two patients referred to us for follow-up chest x-rays from Columbus, Ohio. One was a Negro boy, twelve years of age, who was referred for a chest x-ray as follow-up of a positive tuberculin test done in Ohio. This boy lives with his mother, father and eight brothers and sisters in a two bedroom frame house in the quarters in Lake Placid. This boy is the oldest of the nine children. The mother is now receiving contraceptive medication from her family physician. The other case referred from Ohio was a sixteen year old Negro boy who lives with his father, mother, five brothers and sisters in a one bedroom apartment. The living room has to be used as sleeping quarters at night. These two families have been cooperative and have followed through on recommendations from the Health Department. We are happy to report that we have added two public health nurses to our staff since January, 1966. Both nurses have a B.S. Degree in Nursing and are lifetime residents of this area. We are looking forward to a better nursing program with increased interest in the migrant worker. An I.U.D. Clinic has been set up in the Sebring area which will serve applicants from all areas of the county. A local gynecologist is participating in this clinic. Several migrant workers have attended this clinic. Planned Parenthood Educational Clinics are in process of being organized in the three areas of the county at this time. (Sebring, Avon Park and Lake Placid.)

Efforts are being made to improve aid to the migrant workers and their families and to make a concentrated effort to identify the migrants in this area. This can be done by giving the public health nurses and other staff members a more detailed explanation of the Migrant Program and to make them aware of the need for better communication with the people of the community.

FAMILY HEALTH SERVICES CLINICS

AND NURSING SERVICES

Highlands County

Our experience indicates that additional family medical clinics will be necessary next season.

TABLE I

FAMILY HEALTH SERVICE CLINICS

TYPE OF CLINIC	SESSIONS	HOURS IN CLINIC	PATIENT VISITS	ESTIMATED COST
General Clinics				
Nursing	156	494	194	$1255
Medical				$4315
Dental		360	400	$1260
TOTAL	156	854	594	$6830

TABLE II

HIGHLANDS COUNTY - APRIL 30, 1965 TO APRIL 30, 1966

Public Health Nursing Services for Migrants April 30, 1965 thru April 30, 1966	MAY 1965	JUNE 1965	JULY 1965	AUG. 1965	SEPT. 1965	OCT. 1965	NOV. 1965	DEC. 1965	JAN. 1966	FEB. 1966	MAR. 1966	APR. 1966	HOME VISITS	CLINIC VISITS
Communicable Disease														
Home Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Clinic Visits	33	31	2	13	11	8	0	0	34	7	9	11	-	159
Maternity														
Home Visits	0	0	0	0	0	0	0	0	0	0	2	0	2	-
Clinic Visits	2	0	0	0	0	0	0	2	2	0	2	0	-	8
Infant														
Home Visits	0	0	0	0	0	0	0	0	0	0	1	0	1	-
Clinic Visits	0	0	1	0	0	0	0	0	1	0	0	0	-	2
Pre-School														
Home Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Clinic Visits	0	0	0	0	0	0	0	0	3	0	0	0	-	3
School														
Home Visits	0	0	0	0	0	0	0	0	0	0	0	1	1	-
Clinic Visits	1	0	0	0	1	0	0	0	1	0	0	0	-	3
Tuberculosis														
Home Visits	0	0	0	0	0	0	0	0	0	1	2	1	4	-
Clinic Visits	0	0	0	0	0	0	0	0	3	2	3	0	-	8
Morbidity														
Home Visits	0	0	0	0	0	0	0	0	0	0	2	0	2	-
Clinic Visits	1	0	0	0	0	0	0	1	3	1	0	3	-	9
Mental Health														
Home Visits	0	0	0	0	0	0	0	0	0	0	0	0	0	-
Clinic Visits	0	0	0	0	0	0	0	0	0	0	0	0	-	0
Chronic Disease														
Home Visits	0	0	0	0	0	0	0	0	0	1	0	0	1	-
Clinic Visits	0	0	0	0	0	0	0	0	0	1	1	0	-	2
TOTAL	37	31	3	13	12	8	0	3	47	13	22	16	11	194

GRAND TOTAL: 205

TABLE III

IMMUNIZATIONS

HIGHLANDS COUNTY

AGE	DPT	POLIO	DT	SMALLPOX	TYPHOID
Under 1 year	2	2		2	
1 - 4 years	6	4		10	12
5 years & over	3	10	7	8	30
Boosters - 14 not listed under age groups					
	4		2	5 re-vaccinations	3
TOTAL	15	16	9	25	45

Even though some of the series were not completed because of the instability of the migrants, many persons received immunizations who had previously had no protection.

SANITATION

There are five Migrant Labor Camps in Highlands County. Migrants are also housed in private homes in Sebring, Avon Park and Lake Placid Quarters. Location of these camps is indicated on the enclosed county map. Two of these camps are located in the Lacey Hill area in the Avon Park Colored Quarters. One camp is for men only and contains 42 rooms. This camp had fifty occupants during this season. The other camp has six bedrooms and caters to families only. There were 24 occupants during this season. These two establishments are owned by Mr. M. Kirkland of Avon Park. Sebring has one camp with provisions for housing 24 men. This is a relatively new building (three years old) and is a modern concrete block structure with a good kitchen and adequate toilet facilities. This camp is owned by the Sebring Packing Company (fruit) and is located in the Sebring Colored Quarters. Because of lack of off-shore labor, this camp was not in operation this season. The fourth camp is located on Josephine Creek, midway between Sebring and Lake Placid and is owned by Lykes Brothers. This is a wooden barracks-type building with a concrete slab floor and can accommodate fifteen males. It is kept in good sanitary condition but was not used this season. Consolidated Finance Corporation owns the fifth camp located in the Lake Placid Colored Quarters. This camp is three years old and is a modern concrete block building with excellent facilities and can house 41 single males. This season there were from 15 to 20 occupants. These camps were closed from July 1 to October 15 of 1965 because they are used only for migrant citrus pickers. Some migrants were housed in private homes in the county and much work has been done by this office to raise the standard of living in these homes. The general sanitation program has resulted in cleaner houses, yards and streets in all the colored quarters in the county. In Avon Park, a project is underway and nearing completion to provide low-cost housing and at the same time rid the area of substandard housing. In all three communities, in conjunction with the Aedes Egypti Program, surveys were made and corrections obtained to clean up these areas. The Board of County Commissioners and the towns have provided trucks and man power to dispose of the trash from the yards and streets. Periodic inspections were made of the camps when they were open in order to correct minor violations of the Sanitary Code. Several complaints were made during the season against the two camps in Avon Park owned by Mr. Kirkland becuase of excess garbage and trash and also because of broken sewer lines. These complaints were taken care of by talking to Mr. Kirkland and the camp managers. No complaints were received by this office against any of the other camps.

In Highlands County the use of the migrant in relation to planning, motivating and participating in self-help programs is plagued with false starts which lead to a state of increased apathy. The Vista Program has made some progress in this area. It is felt that this is due to their having the time to follow through with the planned project, being able to concentrate, the time to wheedle, cajole, beg and push until the job is complete. Whether the community will continue these projects reamins to be seen.

Cooperation has been generally very good by agencies, governmental bodies, and employers in helping to improve the general condition. Sometimes this is hampered by a shortage of personnel. The community has organized a community action agency in order to facilitate programs of benefit to the low income group which includes the migrant workers.

The main problem encountered in this county is the number of migrants, their general assimilation and the geographical area to be covered by project personnel. The project area of Highlands, Glades and Hendry covers 2,974 square miles with 75% of the migrants in the two least populous counties. Our Clinician was not obtained until December 1, 1965. An additional Public Health Nurse was added to the budget for the period covered from March 1, 1966 to December 31, 1966 but did not report during the period covered in this report. Change in personnel is also a problem. The nurse in Glades-Hendry returned to school for further education, leaving us with the task of retraining another nurse and the migrants. Recruiting is difficult in the rural areas.

Financial support from the community continues on approximately the same basis as last year (grossly under estimated last year.) The organizations which have health or health related services give consideration on request through the health department. Hospitalization continues to be a problem. Reports from our two hospitals indicate a loss of $4,000. during this period. Efforts were made to get the older workers signed up for Medicare. There has been some use of funds for medical services by the private physicians this year. There are many physicians who still do not bill the migrant program for these services. Estimated value of these services is $1,000. The value of state referral services is difficult to determine in dollars.

These programs should be assimilated into the total community health program which involves welfare, hospitals, nursing homes, private physicians, voluntary agencies and official health agencies. This is the only way to have the best possible comprehensive health program for all citizens of the community.

1966 PROJECT OBJECTIVES

(as related to Highlands-Glades-Hendry)

LEGEND: A = Accomplished

W = Working

F = Failed

A (1) To work more closely with project counties in the technical aspects of the migrant health service program as it concerns medical care.

A (2) To continue to provide opportunity for state and local Public Health Officials and others to evaluate the program for migrants and to plan for its improvement.

(3) To continue to improve the environmental health aspects of the migrants' existance:

W a. Through stricter enforcement of the Camp Regulations

b. Through encouragement of growers to provide field sanitation facilities.

W (4) To develop, utilize and revise when advisable, a uniform system of forms and records for all project counties.

W (5) To test a procedure for extending health education to migrants and compiling information on the migrant population through the use of liaison workers.

A (6) To continue to inform the general public and certain groups of the project's aims and the migrant's problems.

W (7) To involve additional counties in participating in both the health service referral form system and in the migrant project.

A (8) To revise the referral system, where necessary, and encourage its use both within and outside the state.

A (9) To offer more comprehensive medical treatment to migrants in project counties:

a. Through employment of staff physicians to serve as clinicians
b. Through referral to private physicians on a fee-for-service basis.
c. Through employment on a per clinic session basis (contract) of local physicians to serve as clinicians.

A (10) To offer specified types of Dental Services (especially emergency) to migrants in project counties by referral to private dentists on a fee-for-service basis.

(11) To help solve the migrants' problem of transportation:

a. Through use of a mobile clinic in Alachua, Broward, Hillsborough and Seminole Counties.
b. Reimbursement at a specified rate per mile to drivers to transport patients to clinics and offices, both in and outside Glades, Hendry and Highlands Counties.

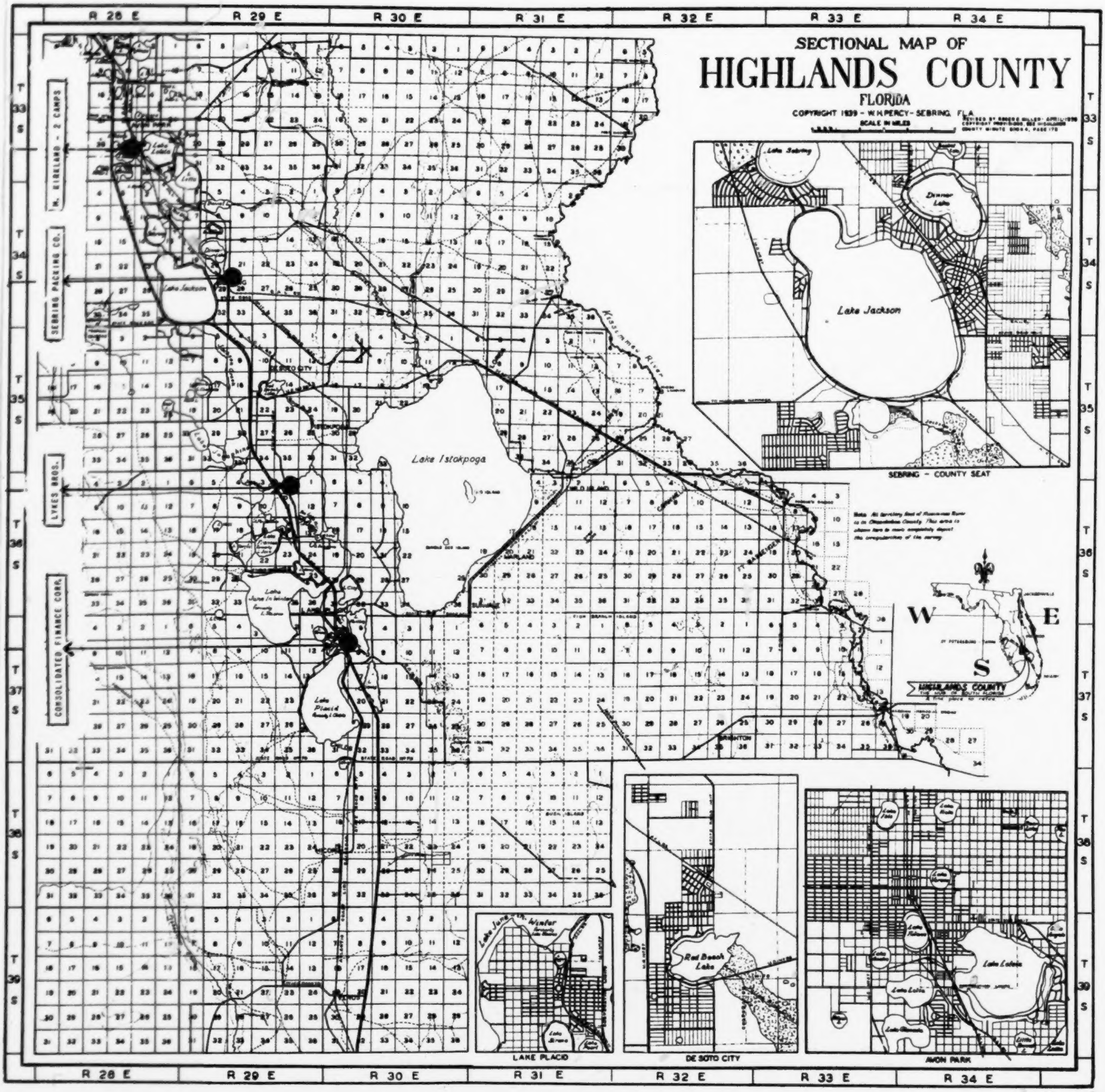
A (12) To cooperate more closely on the state and local levels with any and all groups, agencies and programs involved in working for the betterment of a migrants' lot.

FUTURE OBJECTIVES

(These Future Objectives pertain to Highlands, Glades and Hendry Counties)

Objectives for the future will be continuation of ongoing objectives, more community participation in this Tri-County unit, improved coordination of all efforts on behalf of the migrants; specifically involving the community in day care programs, community awareness and action for better housing and sanitary facilities, coordination with the Vista Program, the Education Program and others.

Our experience in this program is paralleling our experience with our Seminole Indian Health Program. The progress is slow at first, but as results are shown with a few, acceptance begins to improve. Patience is a cardinal principle in this effort.


SECTIONAL MAP OF
HIGHLANDS COUNTY
FLORIDA
COPYRIGHT 1939 - W.H.PERCY - SEBRING, FLA.
SCALE IN MILES
R 28 E
R 29 E
R 30 E
R 31 E
R 32 E
R 33 E
R 34 E
T 33 S
T 34 S
T 35 S
T 36 S
T 37 S
T 38 S
T 39 S
H. KIRKLAND - 2 CAMPS
SEBRING PACKING CO.
LYKES BROS.
CONSOLIDATED FINANCE CORP.
Lake Jackson
Lake Istokpoga
Lake Placid
Kissimmee River
Lake Sebring
Dinner Lake
SEBRING - COUNTY SEAT
W
E
S
HIGHLANDS COUNTY
Red Beach Lake
Lake Lotela
LAKE PLACID
DE SOTO CITY
AVON PARK

27397

LEE COUNTY HEALTH DEPARTMENT

Joseph W. Lawrence, M. D., Director

Area of County: 786 square miles

Resident Population: 70,000

Number of Migrants: 5,000

Migrant Project Staff:	1 Public Health Nurse 1 Sanitarian 1 Clerk Typist (part-time)

LEE COUNTY

PREVAILING DOMESTIC MIGRANT CONDITION

The migrant population in Lee County was estimated in January, 1966 at the peak of the season to be approximately 5,000. Two-thousand (2,000) of these workers, usually single males, remain in the area for several months.

Approximately the same number of fields are planted each year, so we expect about 3,000 workers. Deviation is caused by crop failure or weather. There is a maximum of 2,500 non-working family members.

The ethnic makeup of the migrant is: 7.6% Texas-Mexican; 22.7% Puerto Rican; 67.7% Negro; and 2% White, with average age about 30.

Migrants begin arriving in September. The majority are Negroes from the lower southern states, Mexicans from Texas and Puerto Ricans from Puerto Rico. They usually are gone by June 1, following the East Coast Stream and westward to Michigan and Pennsylvania. Referrals were made this year to Dade, Martin, Palm Beach, Manatee and Sumter Counties in Florida; Beauford and Charleston Counties in South Carolina; and Brevard and Faison Counties in North Carolina with some going directly into Ohio, New Jersey and Texas. We estimate about a thousand workers and nine-hundred dependents leave local homes each June.

Principle crops grown in this area are tomatoes, peppers, squash, cucumbers, corn, watermelons and citrus. The cultivation of flowers is another major source of employment for the migrants here. No known foreign workers are in Lee County and mechanized picking equipment is not used at present.

We should begin now to educate these workers in the use of machinery as their future livelihood may depend upon this knowledge.

LOCATION AND CLINIC SCHEDULES

HARLEM HEIGHTS: Fifteen miles south of Fort Myers in a labor camp. Clinics are held each Tuesday from:

1:00 P.M. to 10:00 P.M.
1:00 P.M. to 5:00 P.M. - Nurses
7:00 P.M. to 10:00 P.M. - Dr. Hagen

TETER ROAD: Eight miles southeast of Fort Myers in a labor camp. Two day clinics, four night clinics each month from:

9:00 A.M. to 12:00 Noon - Nurses
7:00 P.M. to 10:00 P.M. - Two Doctors
Doctor Carver & Doctor Lowery

CHARLESTON PARK (ALVA): Twenty miles east of the City of Fort Myers in a labor camp. Two general clinics a month from:

9:00 A.M. to 12:00 Noon - Nurses

DAY CARE CENTER: Four miles east of the Health Department. Two general clinics a month, one nurse.

HARLEM HEIGHTS SCHOOL: Fifteen miles south of the City of Fort Myers. One session each week, one nurse.

HEALTH DEPARTMENT: (Fort Myers)

Monday	8:00 A.M. to 11:00 A.M.	- General Immunization
Monday	1:00 P.M. to 4:00 P.M.	- General Maternity Clinic
Tuesday	8:00 A.M. to 5:00 P.M.	- X-Ray, V.D., Health Cards
Wednesday	8:00 A.M. to 11:00 A.M.	- General Maternity Clinic
Wednesday	1:00 P.M. to 3:00 P.M.	- General Cytology Clinic

The services offered in our migrant clinics by the nurses are prenatal care, infant and child care, child spacing, Tuberculosis control, immunization, health referrals, V.D. follow-up and counselling.

The doctor clinics are generalized medical service. There are two public health nurses, one paid by Migrant Project funds and one paid by the Childrens' Bureau at each migrant clinic; and two doctors paid by Migrant Project funds, with one VISTA volunteer.

The migrants seen in the Health Department are examined by Dr. Lawrence, Director. All antepartum, postpartum and newborns from all the camps are examined by Dr. Lawrence.

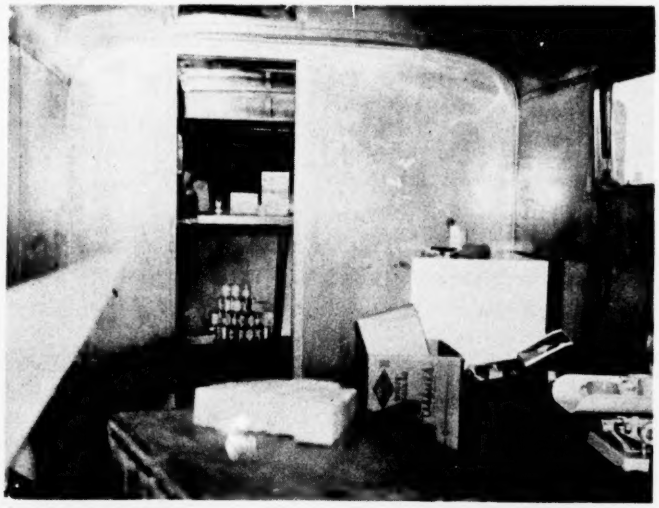
TYPE OF FACILITIES USED IN MIGRANT CLINICS

Harlem Heights: This is a well equipped clinic, consisting of two small rooms, 8 x 10, with bathrooms. The space is donated by fellowships of churches with the use of the Sunday School Department as a waiting room for patients.

GENERAL DAY CLINIC
Patient receiving prenatal care

GENERAL CLINIC - Child
Receiving Immunization

TETER ROAD: This is a stationary trailer on loan from the State Board of Health. It was converted by the project staff for use as a general day clinic and doctor's migrant night clinic. A small Catholic Church was used as a waiting room. Lack of bathroom facilities hindered the clinic work. Some equipment was donated by local doctors, the rest was purchased with project funds. This turned into a community project with the camp owner, VISTA workers and migrants all helping.



The above pictures show interior of trailer being readied for initial operation.

CHARLESTON PARK: The need for a clinic in this all Negro camp was so great that a camp owner donated the use of her home for a clinic. This arrangement was inadequate but the response was most rewarding.

DAY CARE CENTER: This was an old school building, refinished and equipped by Community Action Fund. Fifty (50) migrant children ages 2 to 7 years were housed there from 6:00 A.M. to 6:00 P.M. After receiving a physical examination by the project doctor, a regular immunization clinic was held every other week.

IMMUNIZATION OF CHILDREN AT DAY CARE CENTER

DISEASES TREATED IN MIGRANT OUTLYING CLINICS

January 1, 1966 to May 30, 1966

Diarrhea	AGE GROUP	NUMBER
	0 to 5	M - 18 F - 13
	5 to 15	M - 4 F - 2
NOTE: 86% under five years of age.	15 to 45	M - 0 F - 5
Upper Respiratory		
	0 to 5	M - 45 F - 23
	5 to 15	M - 45 F - 43
Over 15: M - 15% F - 20%	15 to 45	M - 14 F - 33
Under 15: M - 34% F - 31%	45 and over	M - 9 F - 5
Skin Condition		
43%	0 to 15	M - 10 F - 6
40%	15 to 45	M - 11 F - 4
17%	45 and over	M - 6 F - 0
Communicable Disease		
	0 to 5	M - 14 F - 14
	5 to 15	M - 1 F - 2
Parasites		
100%	0 to 15	64
Pregnancies	15 to 45	90

All maternity patients and child spacing clients are given individual counselling as are people referred to any state agency. Much time is spent by project personnel in counselling.

COMPARISON CHART

	June, 1964 to May, 1965	June, 1965 to May, 1966
Immunizations	1,198	1,599
Tuberculosis	4	6
Maternity Visits	291	470
Infant and Health Visits	148	674
School Visits	22	160
Eye Examinations	30	121
Eye Referrals	4	6
X-rays	?	350
V.D.	0	15
Diabetes	0	1
Child Spacing Visits	126	373

TOTAL NUMBER OF CLINIC SESSIONS

July 1, 1965 - May 30, 1966

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May
Patients Visits											
	196	236	123	232	157	172	434	466	532	313	334
Doctors Clinics and Hours											
Clinics					4	4	8	8	8	8	6
Hours					8	8	16	16	16	16	16
Nurses Clinics and Hours (Clinics top line, Hours lower line)											
	17	19	17	16	19	17	24	20	24	20	36
	68	76	68	64	76	68	96	80	96	80	144

TOTAL DOCTORS CLINICS--- 46

DOCTORS HOURS----------- 96

TOTAL NURSES CLINICS----229

NURSES HOURS------------916

FIRST VISITS TO DOCTORS CLINICS

January 1 to June 1, 1966

Puerto Rican		Mexican		Negro		Anglo
Age	0 - 15	Age	0 - 15	Age	0 - 15	None
Male	67	Male	41	Male	13	
Female	51	Female	34	Female	11	
Age	15 - 45	Age	15 - 45	Age	15 - 45	
Male	43	Male	10	Male	16	
Female	47	Female	10	Female	20	
Age	45 & Up	Age	45 & Up	Age	45 & Up	
Male	13	Male	2	Male	8	
Female	5	Female	8	Female	3	

Number of Migrants seen by Nurses:	2,076
Number of Migrants seen by Doctors:	1,119
TOTAL NUMBER	3,195

PERSONS REFERRED

January 1 to May 30, 1966

	Age Group	Sex	Number	Percent of Total
Doctors' Referrals	0 to 5	M&F	35	40%
	5 to 15	M&F	9	10%
	15 to 45	M&F	29	32%
	45 & Up	M&F	16	18%
Dentists' Referrals	0 to 15	M&F	11	30%
	15 to 45	M&F	16	43%
	45 & Up	M&F	10	27%

Miscellaneous Referrals:	Agency Referred To	Number Referred	Age Group
	Active Tuberculosis	8	
	Vocational Rehab.	2	
	X-ray	3	
	Drug Stores	15	
	Laboratory	4	
	Crippled Children	7	0-15
	Council for the Blind	4	
	Rheumatic Fever	2	

The doctor and dentist referrals were made by project personnel to doctors who would treat migrants in their offices at a $4. fee and $3. for each additional visit for the same ailment. The number of these referrals greatly reduced after the night clinics were started with doctors to treat them.

The clinic doctors referred patients to x-ray, laboratory and drug stores for prescriptions paid for by migrant project funds. The prescriptions have been kept at a minimum by use of sample drugs donated by local doctors and drugs boutht with migrant project funds.

Sources of service for these referrals were state agencies and private doctors. All referrals made are presently under observation by state agencies and private M.D.'s and are being treated. Lack of transportation is the reason most of our referrals are not completed.

METHODS OF EDUCATION

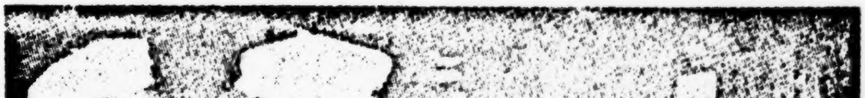
(A) Posters, Flip Charts, Pamphlets and films were used; along with continued teaching by the ~~staff~~.

(B) The sanitary conditions and lack of showers were discussed with camp owners and crew chiefs.

(C) Talks by the Director of Nurses to migrant aides and many other groups.

(D) Use of newspaper articles and pictures, television and radio.

Clinics Held for Migrants



1-7-66

Public health nurses Mrs. Helen M. Meston, left and Mrs. Dorothy Hudson check over Cesario Valdez at the migrant camp clinic on Teeter Road. (News-Press Photo by Lyle Byland)

The second in a series of health clinics for migrants was held Friday night at Teeter Road Camp. The clinics are sponsored by the Lee County Public Health Department, the State Board of Health and the federal government. Mrs. Helen Meston and Mrs. Dorothy Hudson, registered nurses, assisted a doctor in conducting the clinic.

The clinics are held in Lee County to care for workers hampered by a language barrier and constant moving. Migrant workers do not come under county aid nor are they eligible for state welfare. General clinics to immunize migrant children have been held here annually for several years.

Clinics have been conducted for several years at Harlem Heights by Dr. Fred Bartleson and county health nurses. The night clinics are set up so that the entire family may be reached, Mrs. Meston said.

Clinics will be held each Tuesday from 7 to 9 p.m. at Good Shepherd Mission in Harlem Heights. The next Teeter Road clinic will be from 7 to 9 p.m. Jan. 17 at the trailer.

Some problems which hindered the effectiveness of our program this year are as follows:

(1) Lack of clinic space.
(2) Lack of transportation for migrants to attend clinics.
(3) Hours services are offered.

More night clinics are needed to better serve the migrant. A mobile clinic that could bring health facilities to the migrant would solve this problem. The migrant camps are separated by as much as 70 miles and a mobile clinic to reach these outlying areas bringing the clinic right to the migrant is urgently needed. The language barrier has been somewhat overcome by having one RN who speaks some Spanish and one RN who is studying Spanish.

The migrant was reached more adequately by the use of outlying clinics and by opening these facilities during the evening hours when the migrant was able to come without missing much needed work. The clinics now, however, are inadequate as to size and facilities.

The number of referrals made for both family and single males was 150. Very few migrants presented health records when asked.

There was excellent cooperation and working relationships between church groups, Community Action Fund officials and the migrants themselves.

We feel that the migrant on the whole has received the health services well. Many leave their families here the year round and we hope this is because of our available health facilities.

The demand for emergency care has partially been met by our doctors' referrals which permit us to send patients to doctors' offices for a $4. fee. Still needed most urgently is hospital emergency room and in-patient care.

The migrant still has much to learn about acceptance of responsibility and personal health practices but we hope that we have made a beginning.

We feel community understanding of the migrant's problems has improved, therefore, the relationship between migrant and community is better but much more education in this area should be done.

We were not able to serve all migrants in all areas. This was due to the fact that we were unable to take clinics to all areas and many migrants lacked transportation to come to us.

The urgent immediate medical care was met with the outlying doctors' night clinics and referral system to doctors' offices. We attempted health education with every migrant contact.

As no funds were available for hospital care, none could be provided.

We hope in the future to have funds for hospital care, more day care centers, better and more uniform migrant records and a mobile clinic to service all migrants in all areas at hours better suited to their needs.

NURSING SERVICE TO CAMPS

The staff giving service to camps and other places where migrants call home found it difficult to provide adequate service at all times. Our team was made up of two Public Health Nurses and one Sanitarian. A half-time clerk was added May 9, 1966. We did have the use of several VISTA workers and one part-time Gray Lady. One nurse is paid by the Childrens' Bureau.

These camps and areas are scattered throughout the county and several are not in use during the summer months. The camps visited on a regular schedule are:

Harlem Heights - 500 Puerto Rican and Negro families
Charleston Park - 150 Negro families
Teter Road - 350 Mexican families

The camps made up mostly of single males were visited but migrant clinics were not possible because of lack of facilities, nurses and doctors. No nursing service was given except x-rays were taken by a mobile tuberculosis unit in February, 1966. This was accomplished by having good relations with crew chiefs. The Mobile Tuberculosis unit added camps to regular schedules and VISTA workers and nurses went along to register and act as interpreters.

All migrant clinics, except those held in the Health Department, are in labor camps.

The close inter-relation of family health services with nursing service rendered to camps made possible a consolidation of information represented in the narrative and tables in the preceeding section.

SANITATION SERVICES

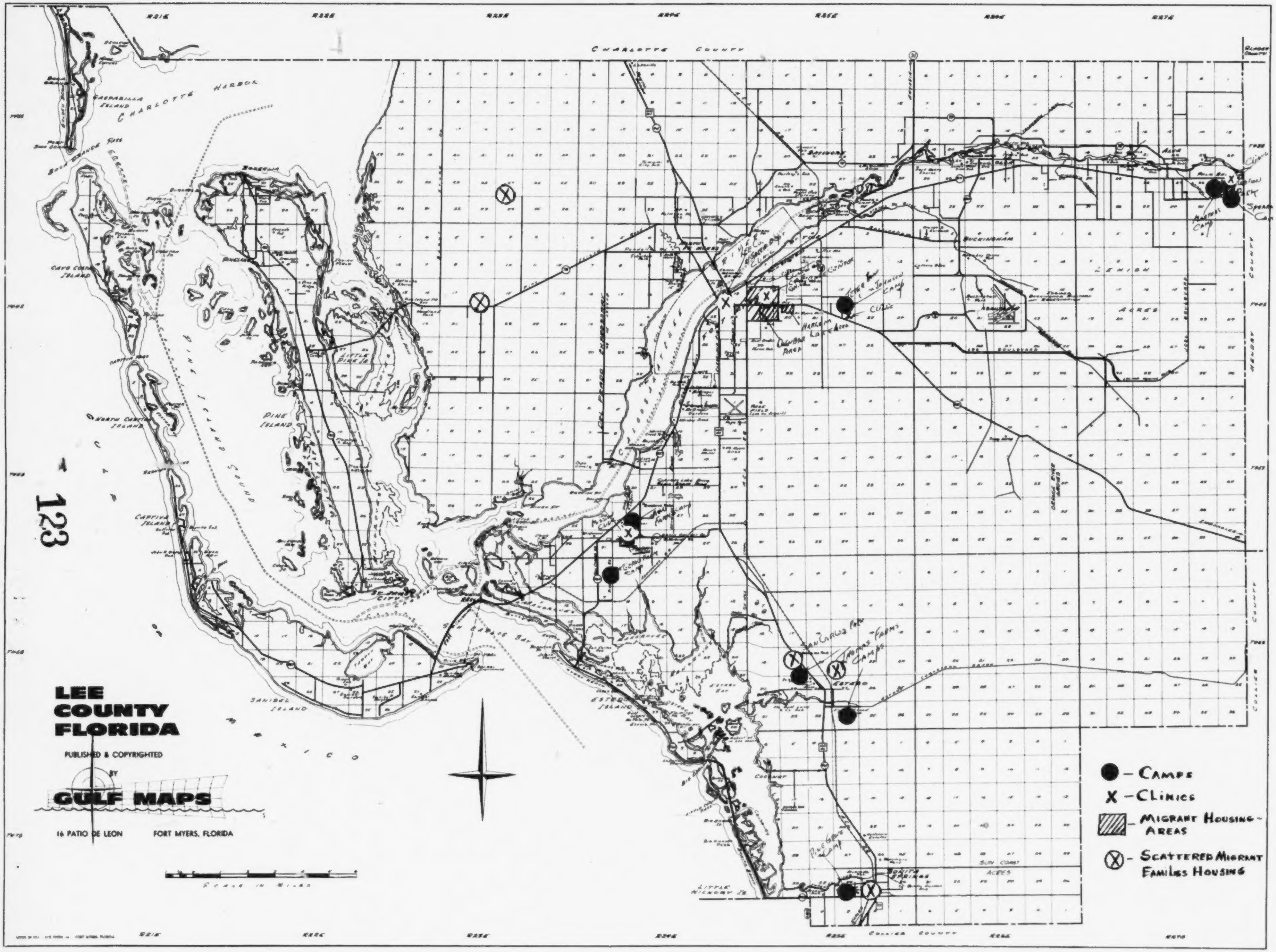
One individual serves as the full-time sanitarian on the project. He is helped from time-to-time by two general sanitarians from the Lee County Health Department, several VISTA volunteers and some of the staff and aides from the local unit of the Community Action Fund.

The appended map shows the location of labor camps, clinics, migrant housing areas and scattered migrant family housing.

Migrant camps are evaluated under the Sanitary Code of Florida, Chapter 170C-32. Migrant housing in the City of Fort Myers is evaluated under a minimum requirement of the City Council.

The following list covers the maximum number of migrants in Lee County at one time:

X	Pine Grove Camp - Bonita Springs	50 migrants
OX	Thomas Farms Camp - San Carlos	60 migrants
X	Thomas Farms Camp - Estero (This camp was closed and consolidated with the above one in San Carlos)	30 migrants
XO	A & W Farms Camp - Iona	50 migrants


LEE COUNTY FLORIDA
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GULF MAPS
16 PATIO DE LEON FORT MYERS, FLORIDA
SCALE IN MILES
CHARLOTTE COUNTY
COLLIER COUNTY
HENDRY COUNTY
GLADES COUNTY
CHARLOTTE HARBOR
GASPARILLA ISLAND
BOCA GRANDE PASS
CAYO COSTA ISLAND
NORTH CAPTIVA ISLAND
CAPTIVA ISLAND
SANIBEL ISLAND
PINE ISLAND
LITTLE PINE IS.
PINE ISLAND SOUND
BOKEELIA
ST. JAMES CITY
SAN CARLOS BAY
ESTERO ISLAND
ESTERO
LITTLE HICKORY IS.
BONITA SPRINGS
SUN COAST ACRES
BUCKINGHAM
LEHIGH ACRES
ALVA
OLGA
GULF OF MEXICO
CALOOSAHATCHEE RIVER
Lee Co. Health Dep. Clinic
Center
Tiller Johnson Camp
Clinic
Harlem Lake Area
Dunbar Area
Clinic
Hall Farms Camp
Gorman Camp
San Carlos Park
Farms Camps
Pine Grove Camp
Clinic
Town Park
Martin Camp
Spears Camp
● – Camps
X – Clinics
▨ – Migrant Housing – Areas
⊗ – Scattered Migrant Families Housing

OFFICE OF THE MAYOR
CITY OF FORT MYERS
FORT MYERS, FLORIDA

PAUL J. MYERS
MAYOR

SEP 17 1965
LEE COUNTY
HEALTH DEPT.

September 17, 1965

Dr. Joseph W. Lawrence
Director
Lee County Health Department
P.O. Box 1226
Fort Myers, Florida

Dear Dr. Lawrence:

This letter will serve to assure you of my full support in your concerted campaign to correct some terrible conditions that exist in our City. Your staff's recent presentation to me, Councilmen and department heads was truly an eye-opening experience.

As was discussed, we feel that a reasonable length of time should be allowed in requiring certain improvements. Having made such a provision however, the deadline established will be relatively inflexible. As your survey and study pointed out so graphically, health conditions are so far below acceptable standards in numerous units, that to defer action indefinitely on these terrible conditions would be ignoring ordinances and health laws that we are all sworn to enforce.

My understanding of the conclusions reached in our conference is this:

1. Your department will interview owners of the worst offenses with appropriate instructions to correct unsafe, unsanitary conditions within realistic time limits.

2. The minimum provisions agreed upon were that each housing unit must have running water inside, a kitchen sink, a functioning flush toilet inside or attached to the building, and minimal standards of safe electrical wiring. All of these improvements would be required no later than 180 days from date of the interview and notice given to owner.

3. Owners would be required to see that their properties were cleared of trash, debris and disease-bearing conditions as provided for in existing City Ordinances. The time allowed for this corrective measure would not exceed 60 days from date of interview and notice.

4. Your department would then re-inspect units at termination of improvement period to determine if owners had complied with requirements.

5. Notice would then be sent to City's appropriate department heads, of any owners who had failed to comply.

Dr. Joseph W. Lawrence
September 17, 1965

Continued - Page Two

6. These departments are instructed to then invoke the penalties of our ordinances upon those who have indicated no willingness to co-operate and make the reasonable improvements during the sufficient time-period allowed.

No doubt the above steps may seem somewhat severe to some owners who have permitted unsafe and unhealthy conditions to invade their properties. But the realization that all of the disastrous by-products of such conditions are not in any way containable, and can quite easily become City-wide, prompts me to pledge you my full support in correcting these disgraceful conditions in our City.

Respectfully yours,

CITY OF FORT MYERS

Paul J. Myers

Paul J. Myers
Mayor

PJM:sh

O	Geraci Camp - Iona	30 migrants
	Harlem Heights Area	500 migrants
	Charleston Park Area - Alva	150 migrants
X	Marth's Camp - 30 migrants) Included	
O	Spearman's Camp - 50 migrants) in above	
X	Johnson's Camp - Teter Road	350 migrants
	Dunbar Area - City	1000 migrants
	Dunbar Area - County	500 migrants
	Harlem Lake Area	300 migrants
	Total	2990 migrants

(CODE: X designates camps permitted for 1965-66
O designates camps predominately single males)

About 2000 additional temporary migrants are in the county at the peak of the season.

Approximately 150 visits were made to eight camps. The two Thomas Farms Camps were in good condition at the beginning of the season. The owner of A & W Farms Camp was contacted before the season started and finally agreed to try the idea proposed to him of having the camp in first-class condition before his crew arrived and to cooperate fully with the Sanitarian. As soon as the crew came in, the Sanitarian saw the crew chief who was very pleased to find the camp in such good condition. The Sanitarian explained the owner's cooperation and the crew chief agreed to maintain the camp as it was. This excellent cooperation worked out well for the entire season with the camp still in good condition at the end of the season. This was the same crew that had been difficult to work with during the previous year.

The five other camps have been improved throughout the year but the Johnson Camp at Teter Road still lacks shower facilities.

The principal camp defects were poorly kept premises, lack of garbage cans and means for keeping them from being knocked over, roads with pot holes that held water, buildings in poor repair, poorly maintained washrooms and lack of bathing facilities.

Except for inadequate bathing facilities at Johnson's Camp (Teter Road) the above defects were, for the most part, corrected. This was accomplished by good cooperation of camp owners and by the migrants better understanding of the need for sanitation. Dr. Johnson provided paint for migrants who wished to improve their own houses. Six families took advantage of this. This cooperation has been encouraged by the sanitarian with help from the local Community Action Fund and VISTA. This same combination was instrumental in getting an Improvement Association started at the Harlem Heights area. This is helping greatly in educating the people in bettering their living conditions. Seventy truck loads of rubbish, accumulated over the years, have been removed, yards have been mowed and improved maintenance of garbage and rubbish has been attained.

The main reason for a lack of full standard camps is economics on the part of the owners. These camps are low rental property that the owners want time to improve on. On the part of the migrant it is a matter of education. It is felt that continued work with the camp owner and the migrant will eventually overcome this.

In Lee County the largest number of migrants are housed in the Dunbar area of Fort Myers and in the adjoining county area, including the Harlem Lake area. In the spring of 1965 a house-to-house survey was made of the city area which encompasses 58 blocks with 761 rental units surveyed. This survey considered:

> The house structure: Windows, screens, roofs, porches, steps, floors
>
> Facilities: Toilets, baths, heating, lighting, sinks
>
> Premises: As to garbage (causing fly breeding), rubbish, wood piles providing rat harborage

Three-hundred-and-twenty units were without baths, two-hundred-and-four lacked sinks and five-hundred-and-thirty-eight had no hot water. This condition was brought to the attention of the Fort Myers City Council; as a result the Mayor asked that the Health Department interview property owners and see that certain minimum requirements were met within realistic time limits.

The Lee County Commissioners passed a resolution somewhat similar to Fort Myers City requirements. The owners were properly advised and as of April 30, 1966 all premises had been cleaned and most of the housing had been brought up to the minimum standards. The housing not yet up to standard will be condemned. The City has five housing units condemned at this time.

The excellent cooperation of most of the landlords and tenants has made for a great improvement in this area. One landlord added twenty some bathrooms, another had provided paint to some tenants who wanted to improve their own housing and has helped make a playground out of a piece of land on his property formerly covered by trash.

A VISTA young man, with help from a Community Action Fund aide and the Sanitarian, has started a Booker Alley Improvement Association which is helping with housing and sanitation in this small area. With continued work with landlords and migrants, support from City and County governing bodies, cooperation of Community Action Fund unit, VISTA and local Health Department, our program will succeed.

The county area, adjoining the city surveyed area, was similarly surveyed in Febryary, 1966 by two sanitatians, one VISTA worker and one inspector from the County Building Department. Eighteen blocks were surveyed covering two-hundred rental units. The results were similar to those found in the city area. The improvements to April 30 have been largely in cleaning up the premises.

VISTA and Community Action Fund personnel are being trained in doing housing and sanitation work by inservice training.

Growers and other camp owners are hesitant to make big improvements because of preconceived ideas that the migrants will not take care of good housing and also because of low-rental income from property. Case evidence that migrants will take care of good housing and will be better workers is gradually changing the attitude of the owners.

The continued education of the migrant by closer contact with the Sanitarian, Community Action Fund aides (who are members of their communities) and by VISTA workers is making the migrant understand the need for his cooperation in maintaining good sanitation and housing.

As stated above, the migrant's education is proceeding well, the camp and other owners' cooperation with the sanitarian has increased and the backing of City and County governing bodies is working out well for future improvement in housing and sanitation in this County.

PROJECT OBJECTIVES THAT CONCERNED LEE COUNTY

(1) To continue to improve the environmental health aspects of the migrants' existance.

    (a) Through stricter enforcement of the Camp Regulations,
    (b) Through encouragement of growers to provide field sanitation facilities.

The project sanitarian improved the environment for migrants not only in camps but in the urban area where the migrants resided this past season. This was accomplished not only through stricter enforecment of regulations but by cooperation on the part of public officials, growers and the migrants themselves. Limited progress was made in the area of field sanitation due to the concentration of efforts to improve housing.

(2) To develop, utilize and revise when advisable a uniform system of forms and records for all Project counties.

The project nurse was appointed to a committee that developed a proposed uniform record system.

(3) To test a procedure for extending health education to migrants and compiling information on the migrant population through the use of liaison workers.

Although migrants were not used as liaison workers in the true sence of the word, we feel that some health education information was disseminated by those migrants who attended our clinics to their fellow migrants. The VISTA workers did assist our staff in the field of health education for migrants.

(4) To continue to inform the general public and certain groups of the Project's aims and the migrants' problems.

Through the staffs' appearance at meetings of various organizations and through television programs and newspaper articles dealing with project activities in the county, this objective is being met.

(5) To revise the Referral System where necessary and encourage its use both within and outside the State.

The project nurse has made certain recommendations dealing with proposed revision of the Referral System. The nursing division of the county health department has made many migrant health referrals both into and inter state.

(6) To offer more comprehensive medical treatment to migrants in Alachua, Broward, Collier, Flagler, Glades, Hendry, Highlands, Hillsborough, Lee, Orange, Polk, Putnam and Seminole Counties:

(a) Through employment of staff physicians to serve as clinicians,
(b) Through referral to private physicians on a fee-for-service per patient basis,
(c) Through employment of a per-clinic session basis (contract) of local physicians to serve as clinicians.

Originally we had planned on employing a physician part-time to serve as a clinician for the migrant program. This was later found to be impossible. Project funds were used however to pay physicians on a fee-for-service basis and also to hire physicians to operate migrant clinics on a per-clinic basis.

(7) To offer specified types of dental services (especially emergency) to migrants in Collier, Flagler, Glades, Hendry, Highlands, Hillsborough, Lee, Putnam and Seminole Counties by referral to private dentists on a fee-for-service basis.

This objective has been met by referring patients to local dentists on a fee-for-service basis.

(8) To help solve the migrants' problem of transportation:

(a) Through the use of a mobile clinic in Alachua, Broward, Hillsborough and Seminole Counties,
(b) By reimbursement at a specified rate per mile to drivers to transport patients to clinics and offices both in and outside Glades, Hendry and Highlands Counties.

Some progress has been made toward solving the migrant transportation problem by using church groups, VISTA workers, migrants and others as chauffeurs so to speak.

(9) To cooperate more closely on the State and local level with any and all groups, agencies and programs involved in working for the betterment of the migrants' lot.

We have cooperated with an received cooperation from many organizations interested in bettering the lot of the agricultrual migrants.

ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

Changes in Lee County's starting date were due to several factors. There was a lack of doctors to man our night clinics at first. As we did not overcome this unitl January 1, the Tables illustrated do not show the true picture as they only date from January 1, 1966.

Even now Lee County does not have a Health Educator, any planned nutrition program or a dental percepter.

In our future planning we hope to have the above personnel plus a part-time migrant doctor, more space to hold clinics and more personnel to operate night clinics badly needed by the migrants. We also hope to have our part-time migrant clerk position made full-time.

We feel that migrant's participation in our health program has been most rewarding. He has been made more aware of the need for immunizations. He asks help from the nurses and sanitarian more readily and when he leaves, comes to us for his records. Also he is more dependable about keeping health appointments made. This improves continuity of health service.

The growers who maintain camps are becoming more cooperative in following recommendations of the sanitarian as to improvement of their camps. This creates a better relationship between grower and migrant.

As a result of better relations between migrants, growers, VISTA workers, etc., the project staff has been stimulated to give better service to reach out to locate more migrants. We are constantly trying to improve our service and facilities. In this we have had excellent cooperation with Community Action Fund personnel and VISTA workers. The Migrant Health Coordinator has been most helpful. The meeting he arranged at West Palm Beach with the entire project staff enabled the different counties to meet and exchange views.

We have had excellent cooperation with the City Council and Mayor of Fort Myers in the field of migrant housing. The Fellowship of Churches, Rev. and Mrs. Reyes of the Good Shepherd Migrant Mission, Rev. Ben Fraticelli, State Director of the Fellowship of Churches, have all worked harmoniously with us.

Our biggest single success was the establishment of the night clinics in two camps weekly with doctors in attendance. This took the clinic to the migrant at hours when he could attend without loss of much needed work. This could not have been accomplished without the aid of a few public spirited doctors who realized their community responsibility.

The biggest drawback in our progress was the lack of mobile clinics to reach many migrants in areas where no clinic facilities were available along with doctors to man these clinics once they were established. These factors could be overcome with a paid migrant doctor with a mobile clinic.

We obtained support for our project from the Fellowship of Churches contribution of space for one of our clinics at the Good Shepherd Mission at Harlem Heights. This was the first group interested in migrants in Lee County and they built a mission at Harlem Heights six years ago. They provided us space, electricity and telephone service all free of charge. Their help has been invaluable to the success of our program.

A new clinic was started at Charleston Park by the efforts of a camp owner who provided space in her home. Layettes were made by different church groups and distributed to new babies. Sample drugs were donated by local doctors; VISTA volunteers worked in some of our clinics and with the sanitarian.

This support from all these different sources will continue in the future and we hope, if funds are available, to add more clinics with doctors in attendance to enable us to reach more migrants.

The project staff has done its best to collect data for the annual report but have been hindered somewhat by lack of uniform migrant records.

The inability to identify the migrant who is absorbed into the community instead of living in camps needs to be overcome. These are mostly Negroes as the Spanish lend themselves to identification more easily.

We would like to be able to do more concentrated work in tuberculosis control. We feel that many tuberculosis suspects are escaping us due to lack of personnel and time to do extensive time consuming follow-up. A case in point:

> A crew leader brought a Negro work crew consisting of about 50 men from Perine, Florida. One man was obviously very ill and sought help from the Health Department. We x-rayed him and gave him a referral to a private doctor. It was found that this man had active pulmonary tuberculosis, far advanced, and was hospitalized immediately. Upon x-ray of all the contacts three more cases of active tuberculosis were found and hospitalized. The other members of the crew went on to Wildwood, Florida. Two of these crew members had suspicious x-rays which were sent to Florida State Board of Health for further interpretation. Migrant Health Service referrals were made on the rest of this crew and they will have to have close follow-up.

If we had personnel to do this, Aerosols would be used to obrain more accurate sputum examinations, more chest x-rays could be done on work crews and certainly many more cases discovered.

Another field in which more work could be done is in the field of Diabetes Control. Our migrant Diabetes case load is very small, but many more cases would doubtless be found with proper screening. Again this is a problem which could be solved with more personnel.

SUMMARY OF ANNUAL REPORT FOR PROJECT GRANT #0885
FROM APRIL 30, 1965 THROUGH APRIL 30, 1966

The hope and plan of bringing better health and living conditions to migrants and their families have been greatly expanded due to the project which enabled Lee County to add a Public Health Nurse in February, 1965 and a Sanitarian in October, 1964 to their staff. Previous to this, the three to five thousand migrants and their families had been served by only one Public Health Nurse in their many scattered camps and locations.

Migrants and their families begin arriving in September and many of them are with us in Lee County until April or May. The ethnic makeup of most of the migrants is Negro, Puerto Rican, Texas-Mexican and White.

Due to the interest and participation of local doctors who realized the plight of the migrant in regard to his health problem, we were able to staff clinics at night. These clinics began at 7:00 P.M. after the migrant had left the vegetable fields for the day and could afford to take the time to seek help for his physical needs. Two such clinics were maintained each week during the entire peak of the season. It was also possible to increase the number of nurse conference clinics and extend these into the various branches of our county where migrants were living and working.

The patients seen by the doctors in the night clinics came for any of the medical and emergency ills of the day to day living. The prenatal patients were all seen in the Lee County Health Department by Dr. Lawrence who is the only physician on the Health Department staff for the entire county. He examined all antepartum and postpartum patients and examined the newborn after it had been delivered by the midwife.

Upper respiratory diseases were the major illnesses for which migrants sought help from the doctors in the night clinic. Closely following this was diarrhea, the majority of patients being in the infant and preschool age groups. Skin conditions ranked third, followed by communicable disease and intestinal parasites.

By bringing immunizations to the migrant in his camp and to the children in the day care centers, many more people were protected against the communicable diseases which are preventable. A total of 1,119 people were seen by the doctor and 2,076 were seen by the nurse.

Through agreements with local doctors to see patients in their offices at a set fee much emergency room service at the hospital was eliminated. Dentists also agreed to see patients for a set fee and emergency dental care was realized for thirty-servn (37) migrants.

Through the cooperation of our local pharmacists, migrants were allowed to fill their prescriptions at drug stores that charged State Welfare rates. Some expense in this field was eliminated by the donations of the local doctors of their drug samples and the fact that drugs were purchased with migrant funds and dispensed to the migrant at the time he was seen by the doctor. This eliminated the possibility, in fact the very great probability, that the migrant would not bother to get the prescription filled even though he could do so at no charge to himself.

Every effort and all available means have been used to bring better health education to the migrant. Talks and films were presented to the migrant himself and news articles and television programs were presented to help the community better understand the migrant problem and their responsibility in meeting this problem.

Some of the major problems which hindered our effectiveness this year and are still facing us in the next year are lack of adequate clinic space, lack of transportation for the migrant to attend clinics that are located in town or at the Health Department. It is also more effective to bring the clinic to the migrant during the hours he is not working which, of course, are the evening hours. A mobile clinic that could travel within the seventy (70) mile area that the migrants inhabit would eliminate this problem if we also had additional nursing personnel to man this mobile clinic.

There is an urgent need for hospital care for the migrant. There is now only one hospital in Lee County and according to their records they lost $14,000. during the past year in unpaid hospital bills, in-patient, from Migrants.

The rewarding work that has been done in making the migrant aware of his health problem and bringing him better health services is merely a beginning. Due to the increase in staff of one nurse and a sanitarian, deeper roots have been planted in this field but unless we have more help it will not be able to expand and grow. For the coming year we feel that we could greatly implement our program with the addition of another Public Health Nurse and by increasing our half-time migrant clerk to full-time. A nutritionist who could give direct service to the migrants in their cultural situation would be a great asset. A dental precepter would also be invaluable both in education, prevention and remedial work.

MANATEE COUNTY HEALTH DEPARTMENT

George W. Dame, M. D., Director

Area of County: 701 square miles

Resident Population: 81,000

Number of Migrants: 5,000

Project Staff: 1 Public Health Nurse
1 Sanitarian

MANATEE COUNTY HEALTH DEPARTMENT MIGRANT PROJECT

I. PROJECT NEED AND BACKGROUND

Manatee County, with an area of 701 square miles (448,640 acres) and a 1965 population of 81,000 people is located on Florida's Gulf Coast in the Tampa Bay region. The principal cities of Bradenton (22,000) and Palmetto (6,500) are located on opposite banks of the mile-wide Manatee River eight (8) miles from the Gulf of Mexico. The cities and the offshore (barrier) islands have long been resorts and the remainder of the county traditionally has had a strongly agricultural economy. There is a large vegetable producing industry in the western part of the county near the cities. The production of ornamentals and citrus is also important in this location and there are 22 large dairy farms. The sparcely populated eastern four/fifts of the county, comprised of the Myakka and Parrish County Census Divisions, is devoted to large cattle ranches and citrus production. Since World War II the population has grown from 27,000 to 81,000, a 200% increase, largely through immigration of older people who have made this a retirement community. This growth, however, has not been at the expense of agribusiness which has also fluorished, now topping 25 million dollars a year and still expanding rapidly. The recent establishment of a deep water port on Tampa Bay, Port Manatee and of a 20 million dollar county-wide water supply will certainly have a strong impact on the economy of this county in the near future.

Vegetable crops include tomatoes, peppers, cabbages, lettuce, eggplant, cucumbers, squash, peas, beans, cauliflower, strawberries, watermelons and cantelopes. Presently there is a total of 100 farmers growing 5,000 acres of vegetables annually. The estimated value is 6 million dollars. In most cases there is adequate local labor to produce vegetable crops, however, there is only one-third of the labor needed to harvest crops. The labor problem is the biggest one the growers have. One-thousand local field laborers and 2,000 migrants are required for the tomato crop alone. Acquiring the necessary number of laborers is becoming more and more a problem because of the lack of suitable housing. Some growers have built their own housing and others have arranged for it but some laborers must seek housing as far as fifty (50) miles away. At the present time the growers are investigating the feasibility of building a large central labor camp. The county is also studying this matter. A suitable labor camp site that is acceptable to the general public is almost impossible to find. Also, the cost of building and maintaining adequate housing in relation to the length of time used during the year (six weeks) makes the building of housing by farmers tremendously expensive. The cost of building a central labor camp is probably too great for the growers alone to sustain. Migrant labor is, however, essential to the agricultural industry.

Vegetable harvesting accounts for the main migrant labor requirement but some workers are needed for citrus. 1,080,000 of the 54,310,000 commercial citrus trees in Florida are located in Manatee County. The annual production is 2,000,000 boxes. Estimated total gross citrus income to the 345 growers is about 5 million dollars annually. There are about 13,938 acres planted in citrus. 200 workers find year-round employment in citrus growing and 600 more are employed during the picking and packing season. Much of the crop is consumed locally by the Tropicana Company.

Ornamental horticulture plays a very important part in the overall economy of the county. Because of the nature of the materials it is difficult to establish a definite situation. There are 90 outlets handling ornamental plants. The annual nursery income is about 2 million dollars. There are at least 42 stores supplying materials essential to the industry. They employ 130 or more people and gross about 1.75 million dollars from garden supplies. The value of ornamentals and turf produced in the county during 1963-64 is:

Cut-flowers and foliage	$ 631,200
Nursery products (liners, ornamental plants, etc.)	360,800
Potato Plants	227,700
Unpotted Plants and Cuttings	57,600
Sod	300,000
Total	$1,577,300

Approximately 500 migrant workers find employment in this industry.

The Manatee County Health Department has had an active migrant program for many years and started a migrant project using State-Federal funds on May 1, 1965 with the establishment of positions for a nurse and sanitarian, whose travel is also paid. The work accomplishments for the past year of the nurse and sanitarian are included in subsequent pages. The VISTA Camp was moved from Rubonia to Tallevast in September in order to make way for the 15 million dollar Borden Chemical Plant construction. In the new location buildings have been constructed especially for the VISTA program and include administration offices, dormitories, classrooms, dining room, kitchen and sanitary facilities. The camp has accommodations for about 100 trainees and has graduated a class with over 90 members. The Health Department assisted in approving plans for the new camp, its sanitary facilities and water supply. Various Health Department personnel have also participated in the training program. We expect that headquarters of the Community Service Foundation and Community Action Fund will be moved to a location near the VISTA Camp in the next few weeks. The Director of this state program has announced these plans publicly. The multiservice center referred to last year has been operational since January and has an average census of about 150 children, many of them migrants. The plans described in last year's continuation request have, in the main, been implemented as described in the nurse's progress report.

A mobile health clinic will be in operation by the middle of August this year. The mobile clinic was paid for with funds obtained from the local Board of Education. The Medical Society has not yet chosen to participate in a Federally paid program for migrant medical services and continues to see them mainly in the emergency room of the hospital, usually without collecting a fee. Medical services for migrants remain a problem in this county. In 1963 a questionnaire was mailed to the physicians. Twenty per cent of the doctors who answered the questions indicated a need for clinics for migrants. A summary of the questionnaire is as follows:

QUESTIONNAIRE MAILED TO PHYSICIANS NOVEMBER 15, 1963

Questionnaire Mailed To	Number	Response Number	(Questionnaries Ret.) Per Cent
Medical Doctors	53	31	58%

Doctors of Osteopathy	7	7	100%
Chiopractors	1	0	0%
TOTAL	61	38	62%

The Questionnaire was typed on an addressed, stamped postal card. The six questions and the response to each were as follows:

	#	%
(1) Approximately how many migrants consulted you last year?	34	89
(2) About how many required hospital admission?	24	63
(3) Were their health problems about the same as those of the general population or did they differ in any definite pattern?	23	60
(4) Was general health of migrants about average for community?	21	55
(5) Did migrants pay you for your services? Always, Usually, Average, Rare	23	60
(6) How can migrant health be improved in our county?	19	50

Question 1. Approximately how many migrants consulted you last year?

Question not answered.
Two of these doctors indicated they saw migrants, but never-the-less failed to answer this question.

Question Answered	34
Saw migrants	12
Doctors who treated migrants	24

Total number of migrants seen by 24 doctors

Range	1 - 125
Average	18 +

Question 2. About how many required hospital admission?

Question not answered 4
Two of these doctors indicated they saw migrants and probably hospitalized some, but never-the-less did not answer this question.

Question answered	22
Saw migrants and hospitalized none	9
Saw and hospitalized migrants	13

Total number of migrants hospitalized by 13 doctors

Range	1 - 25
Average	6 +
Per Cent Hospitalized (81/439)	18%

Question 3. Were their health problems about the same as those of the general population or did they differ in any definite pattern?

Same	18
Different	5
No answer	18
TOTAL	38

Question 4. Was general health of migrants about average for the community?

About average	13
Below average	15
No answer	18
TOTAL	38

Question 5. Did migrant pay you for your services? Always, Usually, Average, Rare

Always	2
Usually or Average	6
Rare	13
"About 2/3 paid"	1
No answer	16
TOTAL	38

Question 6. How can migrant health be improved in our county?

Question not answered	18
Impossible	2
Eliminate migrants, prohibit migration, etc.	3
Higher wages for migrant labor	1
Improve housing	3
Health education for migrants	3
*Clinic arrangements	4
Public health assistance	2
Medical examination on entering county	1
Enforced health insurance managed by crew leaders	1
TOTAL	38

*Clinic arrangement paid for by:	
Grower	2
County	1
Unspecified	1

II. PROJECT OBJECTIVES

(1) Maternity Clinic Service. Prenatal and postnatal care. Hospital delivery.

(2) Home visits to maternity clinic patients.

(3) Well-child clinics. Examinations

(4) Health Education.

(5) Planned parenthood program.

(6) Health surveys and evaluation.

(7) Medical services - treatment. None will be offered. This is a real need.

(8) Environmental Health Services.

Project Need and Background: There are three to five thousand migrants here six to eight weeks annually. All are concentrated in a relatively small area in the western part of the county, few more than eight miles from the health department. There is a serious shortage of housing and much of what is available is substandard. General health is under par (see enclosed physician questionnaire) and there is no system for providing care. Almost all wait until seriously ill then go to the E.R. at the hospital where they are often treated over the phone by a nurse - many are admitted to the hospital. Considerable economic loss accrues to the county.

III. METHOD OF PROCEDURE TO MEET OBJECTIVES

(1) Applications for the maternity clinic are accepted at the county Welfare Office in the courthouse. Cases applying to the Health Department are referred there. After approval by County Welfare, cases are referred to the clinic at the Health Department. Complete medical evaluation is performed at the first visit. Cases are thereafter examined at least once monthly or more often if needed. When labor begins, the patient reports to the E.R. of the hospital where she is admitted. All cases are delivered by an obstetrician. After delivery, a nurse makes a minimum of three home visits. The patient returns to the clinic at six weeks for post-natal examination. The baby is examined by a pediatrician before leaving the hospital and again in the Health Department clinic at eight weeks.

(2) After dismissal from the hospital, a nurse visits the next day in order to determine the condition of the home and of the mother and newborn. She makes two more visits before the mother and child return to the clinic for post-natal examination.

(3) Well-child clinics are made available to children of migrant families. There is a clinic each Wednesday afternoon at the Health Department located at 202 Sixth Avenue, East in Bradenton. There is a clinic the first Tuesday of each month in Parrish, a clinic the second Tuesday at Rubonia, a clinic the third Tuesday at Palmetto and a clinic on the fourth Tuesday in Tallevast. All of these outlying clinics are located in places where migrants live and work. They are staffed by the County Health Director (who is a physician), one or more nurses and sometimes clerical personnel. Many children of all ages are given careful health evaluations in these clinics. Some are found to have chronic or acute diseases and arrangements are made for treatment. Children with dental problems are referred to the Public Health Dentist.

(4) Health Education. The nurse and sanitarian visit many migrant homes for the purpose of giving instruction in matters pertinent to good health and sanitation.

(5) A planned partenhood program is offered to every patient in the maternity clinic. About 40% have tubal ligations during confinement. Others are given oral contraceptives or vaginal foam. One-hundred intrauterine devices were inserted last year.

(6) Health surveys and evaluations. On a modest scale, we have made several surveys for intestinal parasites and for tuberculosis.

(7) Medical Services. Unfortunately, there is no program to provide therapeutic clinical services to migrants. The Health Director continues to work with the Medical Society to develop a program.

(8) Environmental Health Services. See report by Sanitarian.

IV. PROJECT STAFFING

The project is staffed by one nurse and one sanitarian, whose local travel is also paid. Between five and ten per cent of the time of other health department employees is devoted to migrant programs. The cost of all clerical aide to the migrant project is absorbed by the Manatee County Health Department budget. No additional staff is requested. The present Health Department staff of 40 includes 14 nurses, 9 sanitarians, a sanitary engineer and a dentist.

V. FACILITIES AVAILABLE

The Manatee County Health Department building at 202 Sixth Avenue East in Bradenton has 6400 square feet, exclusive of 1900 square feet in the pollution control laboratory. The clinic space is quite adequate. The outlying clinics are held in various community buildings.

VI. BUDGET EXPLANATION

Project funds are requested to pay the salaries and travel of sanitarian and a nurse. No other funds are requested. One-hundred dollars a month will usually cover local travel. Out-of-county travel is paid by the county budget.

VII. PARTICIPATION OF OTHER AGENCIES

The Manatee County Health Department migrant project is not dependent upon other agencies. It works closely with a number of State, County, Federal and private agencies.

VIII. PROJECT EVALUATION

A complete listing of all patients served by the migrant project will be maintained.

IX. PLANS FOR CONTINUING SERVICES

The migrant project will be continued as long as funds are available. Should funds no longer be available, the project will be curtailed.

X. SUPPORTING DATA AND OTHER INFORMATION

See enclosures.

MIGRANT PROJECT

PUBLIC HEALTH NURSING PROGRESS REPORT

I. Family Health Service Clinics

Because of limited participation of Manatee County in the total Migrant Project, Health Service Clinics have been limited in the main to immunization programs with teaching in care and prevention in areas such as intestinal parasites and care of skin diseases in children, the need for early and continued pre-natal and post-partum care and a constant effort on the part of the nurse in urging the ill migrant to seek medical care for other health problems. In addition to its own programs Manatee County Health Department maintains cooperative programs with other agencies. The Seasonal Agricultural Workers Council, incorporated in 1965, contributes services and items such as clothing, furniture, etc. when a need is known. The Multi-Service Day Care Center in Palmetto operating under Suncoast Progress and serving an average daily census of 150 children, many of whom are of migrant families, is visited regularly by Health Department nurses and clinics for immunizations, etc. are held monthly.

The Health Department Maternity Clinic does accept migrant women but because screening and approval for this clinic is handled through the office of County Welfare and partial payment of hospital costs is demanded, many of the migrant women will not make the effort to obtain this care, especially early in their pregnancy. One of the great concerns and complaints of local practicing obstetricians is the high number of patients who walk into the local hospital to deliver without having had any pre-natal care. (See Table I)

Clinics in the migrant camps have been staffed by the Migrant Project Nurse with occasional help from Vista Volunteers. All clinics have been held in the daylight hours, arranged whenever possible through first contacting the grower for approval then making preliminary visits and agreement with camp residents about when will be the best time for them to make themselves available for services. Because they have been strictly nursing clinics and because of the time element, the greatest service has been to children.

II. Type of Facility Used at Each Clinic Location

Clinics have been held most frequently in the kitchen area of the migrant camps, although occasional clinics have been held in the open from the back of a station wagon. Early in the project year several clinics were held in a small house occupied by Vista Volunteers in Cranes Quarters, a migrant settlement. This facility was later condemned by the Sanitation Department, however, and abandoned.

Clinics have also been held regularly in the Day Care Center established under Community Action Fund and located in Rubonia, a small community in the center of the growing area. Here, with a captive audience, approximately 55 migrant children, and the rest of the families who work a part of each season in the fields, have been immunized. (See Table II)

III. (a) Clinic sessions and services during project period. (See Table III)

(b) Total number of individuals seen in clinics throughout project period. (See Table III)

IV. Persons referred to other sources of service during project period. (See Table I)

V. Examples of Purposes and Methods of Educational Effort

Areas where teaching efforts have been most readily accepted are, of course, those of most immediate concern to the migrant.

Care of skin diseases such as impetigo, Florida sores, allergic reactions, etc. are always of prime concern as these conditions are so common with this population. (See Table I)

It is hoped that constant and repeated stress on proper sanitation and personal cleanliness and health habits will reduce the incidence of diarrhea and acute intestinal upsets. This problem continues to be one frequently seen, encountered and can be severely debilitating to the migrant.

We also find the migrant women especially receptive to information concerning any method of planned parenthood. (See Table I)

During the project year we have had, in conjunction with the Health Department Maternity Clinic, both cancer detection and I.U.D. clinics with a good percentage of migrant women participating. (See Table I)

A continuing problem is how best to provide medical services to the migrant. Frequently they do not seek medical help until they are acutely ill and an emergency exists. They will then go to the hospital emergency room for help. This often results in a hospital admission (for which the migrant can seldom pay) that might have been avoided had he been seen by a doctor early in his illness. The County Welfare Department reports that migrant hospitalizations have cost the county over $100,000.00 this year. It is hoped that with closer personal contact through home visiting clinics, etc. we may begin to gain the confidence and consequently the cooperation of this population in taking a more direct responsibility for their own health. Because many of the migrants speak and understand only Spanish, we have frequently called on Community Action Fund and Vista Workers to assist as interpreters. They have been most cooperative in this matter.

In summary, the Public Health Nurses work in the Migrant Program represents generalized public health nursing services to this often medically and socially deprived group who spend a portion of their time in our county each year.

TABLE I

PARASITES		SKIN CONDITIONS	PREG. & MATER. FOLLOW-UP		PLANNED PARENTHD.	REFERRALS			
No. Surv.	No. Pos.	No of Cases Found	Clinic Pats.	Non-Cl. Pats.	Seen in Clinic	FCC	KIWANIS	LIONS	FCB
90	48	80	19	10	21	6	2	5	2
			TOTAL	29		TOTAL			15

(1) Stool specimen containers are given to migrant families with small children almost routinely - Many are never used but all positive reports received in office are followed-up and treatment or referral to private physicians.

(2) Nineteen (19) of twenty-nine (29) maternity patients followed were approved clinic patients who were seen in regular clinic sessions for some part of their pregnancy, through Post-Partum and Six Weeks check-up. Ten (10) were never approved but were followed and encouraged to seek private physicians.

(3) Both oral contraceptive pills and Intra-Uterine-Devices have been available at the local health department. We have had nine (9) migrant women with I.U.D. inserts and many more placed on pills or Emco.

(4) Referrals to other agencies, Crippled Childrens' Commission, Council for the Blind, etc., unless of an emergency nature, are often not followed through simply because the migrants leave the area before the referral can be completed.

TABLE II
IMMUNIZATIONS (CHILDREN)

	DPT		POLIO (Oral)		DT & BOOSTERS	SMALLPOX
AGE (Yrs.)	Comp.	Incomp.	Comp.	Incomp.	Comp.	Comp.
0 - 15	80	108	54	101	35	51
	TOTAL	188	TOTAL	155	35 TOTAL	51 TOTAL

NOTE: This Table represents only children immunized in outlying clinics and the day care center. Several migrant children are seen each week in regular well-child clinics held at the County Health Department.

TABLE III

CLINIC INFORMATION			
CLINIC LOCATION	NO. CLINIC SESSIONS	HOURS PER LOCATION	PATIENT VISITS
Day Care Center	11	33	N K
Migrant Camps	14	42	N K (*)
	TOTAL 25	TOTAL 75	TOTAL 418

(*)The total "Patient Visits" represents only children seen in the various outlying clinics and day care centers. Many adults of the migrant population were seen in clinics held regularly at the Health Department.

TABLE IV

IMMUNIZATIONS (VISTA)			
TETANUS SERIES	TETANUS BOOSTER	TYPHOID SERIES	TYPHOID BOOSTER
96	56	109	28

NOTE: With the establishment of the Vista Training Camp in this area, we have provided Vista trainees with immunizations for Tetanus and Typhoid.

MIGRANT PROJECT

ENVIRONMENTAL HEALTH PROGRESS REPORT

The population served by this project is located in the southwestern portion of Florida. Bounded by the Gulf of Mexico on the west, Sarasota County on the south, DeSoto and Hardee Counties on the east and Hillsborough County on the north, the population of Manatee County is estimated at 80,000 persons at the present time. Manatee County has an area of 701 square miles or 448,640 acres, consisting mainly of coastal plains. The county is mostly level with gently rolling topography in the central and northwestern areas. The northeast tip of the county has an elevation of 150 feet with an elevation to sea level along the Gulf Coast. Within this county an estimated 3,200 migrant agricultural workers, excluding their dependents, reside during the "season" which begins in earnest in January and ends about June 10 to 15.

A fall crop of tomatoes is tried by some growers from time to time, while a few regularly plant a smaller crop. The season for this crop is from around October 20 to December 15. Most of the laborers used in this operation are recruited from local sources. Some resident seasonal agricultural workers having returned from the East Coast Migrant Stream, join in this work and at the same time bring their school-age children back to enroll in school.

The Farm Labor Office, Florida State Employment Service estimates this migrant population to be composed of the following:

Mexicans (Texas-Mexicans generally)	40%

Puerto Ricans	10%
Southern Negroes	50%

The number of Anglos or Caucasians encountered as seasonal migrant agricultural workers in this county is so small as to be negligible for purposes of this report. An estimate has been made that only 15 to 20 workers are needed for 1,000 acres of citrus, 500 workers to 1,000 acres of gladiolas and 1,500 workers to 1,000 acres of tomatoes. It is, therefore, self-evident that by far the largest majority of seasonal agricultural workers are primarily used in the tomato crop operation for Manatee County. Other truck crops such as strawberries, beans, cucumbers, eggplants, etc. count for employment of some seasonal agricultural workers outside of, and in some cases coincidental with, the regular "season." A number of seasonal agricultural workers are employed during the late summer and early fall by two large grass (sod) farms.

Most of the migrants arrive in the area around April 1 through May 15. The exact date depends upon the work availability here, crop longevity in the last area as well as previous committments to growers either in the southern or northern portion of the Atlantic Coast Migrant Stream.

Most of the migrants begin to leave around June 6 through 10 (depending on availability of work here or previous committments) and are gone by June 20. Most of the seasonal agricultural workers in this area come from Belle Glade, Homestead, Immokalee and other southern portions of the stream. From personal interviews it appears that a very large majority of the Negro migrants originally came from Georgia, Alabama and Mississippi with relatively few native Floridians. The Mexicans are predominately from Texas with a few from Oklahoma. The majority of the Puerto Ricans seem to migrate annually from Puerto Rico and then back to there until the start of the next season. Some Puerto Ricans have come into the stream from large northern cities.

The migrants leaving this area seem to generally follow the Atlantic Coast migrant stream with some deviation to mid-eastern states as governed by labor committments. On the other hand, some of the Mexican crews go back to Texas, some to Louisiana, Oklahoma, Ohio, etc. We have no exact knowledge as to towns and counties where the workers are going; due in part to the ignorance of the average migrant as to where he will go next and to the reluctance of the crew leader to tie his route down, even verbally.

During the past summer months (1965) a Migrant Survey was made to help determine the approximate number of 'migrants' who actually maintain year-round homes in this county. The survey used the house-to-house interview method and was conducted mainly in housing fringe areas which were known to have migrant residents and in out-lying areas where the housing was predominately near the sub-standard level.

A total of 213 private residences were surveyed. Out of this number a total of 38 migrant families in individual houses were discovered. In this group there were 170 persons dwelling in the homes with a total of 206 in the represented families; making a total of 36 persons in the families who were "on the season." The relatively high number of persons in dwellings as compared to the total number in the family is partially due to the fact that as the survey progressed and the summer ended, more migrants returned early to no available work "up the road", thus swelling the "number in dwelling" figure. The seasonal agricultural workers represented in the survey group left this area at about the same time as the regular migrants (June 15 - 20). They returned in an uneven flow from July 15 until at least the middle of October.

Surprisingly enough, the breakdown by ethnic groups revealed that of the total number of persons surveyed, forty-four percent (44%) were Mexicans, forty-four percent (44%) Negroes and twelve percent (12%) Puerto Ricans.

It also appears that more and more Mexican families are stopping off in Manatee County and establishing this area as "home." It is our opinion that this is an indication of a future trend for the migrant families to drop off and establish homes along the Atlantic Coast migrant stream route, especially in the southern states.

The number and location of camps and other major concentrations of migrant housing are covered under sanitation service.

The 1965 spring tomato crop season was approximately 13 weeks in duration with ideal growing conditions. There seemed to be very little problem due to scarcity of labor. The current year, 1966, was marked by a hard freeze in January which necessitated nearly 100% tomato replanting in Manatee County. This materially shortened the season with the first picking being around May 6. Due to the heavy harvest and to the fact that nearly all pickings coincided, a serious labor shortage was felt. It is estimated that there were from 10 to 15 per cent fewer migrants than during the last season, credited by some at least to the local housing conditions.

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

STAFF:

1 Public Health Nurse I	100%
1 Sanitation Trainee	100%

The project was approved for one (1) Public Health Nurse II and one (1) Sanitarian II. The position of Senior Sanitarian has been approved for the Sanitarian II position and will be filled by a Sanitarian who is so qualified. The Public Health Nurse I has been promoted to Public Health Nurse II.

There were no volunteers used in the carrying out of sanitation activities.

Laws, Regulations or other criteria for evaluating camps

Camp evaluation procedure has been developed in conformance with Cahpter 170C-32 of the Sanitary Code of Florida.

Camp Locations in Manatee County - Table #1

Number of Camps in Area by Type and Population - Table #2

Purpose of Visits

Total number of camps visited------------------	8
Total number of visits to camps-----------------	203
Water Supplies, sampling, etc.------------------	73
Sewage disposal systems------------------------	23

Child Care Centers	15
Investigation of complaints	72
Complaints corrected	18
Conferences	33
Inspections-Food Service Facilities	24
Public premises	66
Private premises	406
Other	116
Total number of visits	1049

At the beginning of the project there were eight (8) camps which met minimum standards. During this project period there was a consolidation of two (2) camps into one (1) at a new location; one (1) relocation and expansion of one (1) and one (1) new camp constructed. At the end of the season there were only eight (8) camps and seven (7) of these were permitted by the Florida State Board of Health.

TABLE II

NUMBER OF CAMPS IN AREA BY TYPE AND POPULATION

Key No.	Name	Purpose	Permitted for
4	VISTA Camp (*)	Training VISTA Personnel to work with migrants and migrant problems	90
5	Valley Farm	Migrant Labor Camp	100
8	Whisenant	Migrant Labor Camp	135
2	Jackson Field	Migrant Labor Camp	36
6	Foy	Migrant Labor Camp	66
1	Ellenton-Gillette	Migrant Labor Camp	47
3	Warren Edwards	Migrant Labor Camp	65
7	Fulton	Migrant Labor Camp	40
	Hatcher	(Not completed, not permitted) Constructed as Labor Camp, not operated past year. Licensed as hotel by Florida Hotel and Restaurant Commission. Not Permitted this season.	72
	Wards	Being repaired with new construction taking place toward securing a Labor Camp permit. Unpermitted	66
		TOTAL CAMP POPULATION	717

Chief Methods Used in Obtaining Correction of Defects

Migrant labor camps in Manatee County are permitted in accordance with Chapter 170C-32, Florida State Sanitary Code. The Manatee County Building, Electrical and Plumbing Codes must be conformed with as well as the fire marshall's recommendations and previously mentioned sanitation regulations with a final inspection being made before the permit is issued.

The chief method used in obtaining correction of defects in camps is that of personal consultation and discussion. The majority of defects noted are usually corrected after they are identified specifically and explained sufficiently to the crew leader or camp supervisor. We have no camps large enough to have a camp maintenance foreman. Correction even of minor defects takes repetitious action; rarely does one visit correct more than one defect. Major defects concerning water supply problems, structural defects, garbage disposal, inadequate housing, etc. are discussed with camp owners and, when necessary, followed up with certified letters delineating the defects. It has been necessary to send few letters.

Generally, the reason for not repairing building defects of a minor nature is apathy (in both crew leader and crew) toward the entire housing problem. The crew leaders are difficult to find in camp for a detailed joint inspection. When the crews come in from the fields they are tired and dismiss any problems except personal ones. On larger defects which would require money to be spent, the owner or operator is reluctant to make an expenditure which he feels may be wasted. It is absolutely essential that the sanitarian work very closely with both owner and crew leader and gain their confidence and respect as one who knows what should be accomplished. Even owners who talk at spending money will, in time and with proper persuasion, make suggested repairs, etc. It is, no doubt, frustrating to the owner to be continually plagued with the same "reason." The entire aim of owners, crew leaders and even the migrants themselves is directed towards the "crops" and its financial impact on their lives.

During the preparation period of the camps during the past season, a severe freeze killed practically all of the tomato plants in the Manatee County area. Everyone concerned; the owners, available crew leaders and migrants were utilized in a vast replanting operation.

Other Types of Housing Used by Migrants

The number of migrants living in private homes, rooming houses and apartments not included in enumerated camps is approximately 2600, or 81% of the total number of migrants in this county. This housing is located predominately in the municipalities of Bradenton and Palmetto, however a number of families live in the rural and unincorporated areas.

Laws, Regulations or Other Criteria for Non-Camp Housing Evaluation

Many of the non-camp housing establishments (rooming houses and apartments) are regulated and licensed by the Florida State Hotel and Restaurant Commission. Individual or single-family residences and duplexes are not subject to either the Florida State Sanitary Code as applied to Camps (Chapter 32) or to the Hotel and Restaurant Commission regulations. Consequently, the laws of the State, as well as local legislative acts are used for regulations and for the correction of insanitary conditions. Manatee County has Zoning, Building and Housing regulations which are enforced by the respective county inspection department. The Southern Standard Building Code is used as criteria by the Building Department.

Sanitation Services to Migrant Housing Outside of Camps

It is estimated that Manatee County has 65 general locations (including rural single houses) in which seasonal agricultural workers reside. This is, of course, both singly and in family groups. Thirty-eight (38) of these locations were visited during the project period. These were generally as individual family units in "fringe" or rural areas. This was done as part of an investigational survey conducted during the summer of 1965. This was a house-to-house survey which necessarily required contacts being made at many houses where migrants did not live. No specific record was compiled as to housing inspections as the prime mission of the survey was to get the overall picture of the permanent migrant family; i.e. those families that maintain a residence in the county having one or more members follow the stream. Defects noted which were of a flagrant nature were reported to the owner or landlord with follow-up made after an appropriate interval. It is our opinion that the major difficulties are caused by simple overcrowding of small units. Due to over-loading, some septic tank failures were noted, but generally the lack of personal sanitary facilities was predominant.

Field Locations

There are at present approximately 100 farmers in Manatee County growing 4,500 to 5,000 acres of vegetable crops. (This is an estimate) from the "Extension Program Projection - Manatee County" put out by the Florida State Agricultural Extension Service.

Sixty-five (65) visits were made to 27 separate fields during the project period. We have no field inspection form but personal notes were taken as to major discrepancies.

In the majority of cases, drinking water was taken to the fields from an approved camp or city water supply. When otherwise, crew leaders were told to secure an approved supply and were checked. A common drinking cup was in evidence in practically every field at the beginning of the season. Efforts to encourage the use of single service paper cups was resisted, but some success was noted by the end of the season. Four (4) fields have free running artesian wells and handwashing facilities are available. Three (3) owners furnish field toilets; the balance use nearby woods or the fields. Approved portable toilets are now available for rental in this area. Garbage is held to a minimum by the person or persons who bring sandwiches and 'soft drinks' into the fields at noon. It is to be noted that the use of 'soft drinks' in their plant sterilized bottles for field consumption is far more desirable than the drinking of water from questionable sources and from questionable containers. Regulations concerning field sanitation as such are not in existance with the exception that general provisions of the Florida State Sanitary Code may be applied.

It is strongly recommended that much additional thought and study be directed to this facet of the Migrant Health Project. More educational and regulatory work should be done in this area. Efforts in this direction will be undertaken in this county.

Examples of Purposes and Methods of Educational Effort

Educational work was done by the sanitarian with owners, crew leaders, individual migrants and other disciplines in the field. In general, this was on specifics as results of discrepancies noted; new camps being built, old camps being relocated, enlargement of camp facilities, etc. The situation was presented, specific governing regulations were noted, and then general discussions and conferences as to when and how the problem might best be solved was the general format on discrepancies of a major nature.

Conferences by sanitarians in reference to health education were held on the following subjects: Sanitary facilities, shelter, fire protection, water supply, sewage disposal, plumbing, camp site and general.

Specific problems by example involved in counselling in sanitation

Sanitary Facilities:

Plans for relocation, redesign, and new camps are submitted to the Health Department for review and recommendations prior to work being started. Health Department approval must be obtained prior to issuance of a county building permit.

Shelter:

General discussions with crew leader in minor cases. Specific instruction to owner and/or crew leader in cases of major damage such as caused by storms, etc.

Fire Protection:

Prior to the permitting of a camp, there is an inspection and recommendations by local fire inspectors. Results of such inspection plus specific recommendations are sent each camp owner for his camp. Then follow-ups are made to secure compliance.

Water Supply:

Water supplies for camps are checked and bacteriologically sampled at least three (3) times during the season. When found not satisfactory, the owner is so notified and given remedial instructions. Follow-up visits are then made with repeat samplings until the conditions have been corrected and satisfactory water quality is achieved. If the water bacteriological quality is found satisfactory the report is, of course, also sent to the owner.

Sewage Disposal:

Plans for sewage disposal in new and expanded camps are reviewed and approved prior to construction. A check is made during the construction of the facility and upon completion before a camp is permitted.

Facilities at established camps are checked several times during the season for compliance and satisfactory operating maintenance.

Plumbing:

All plumbing in camps is under the regulatory and inspection service of the county plumbing department. Plumbing maintenance is one of the greatest headaches in migrant camps. For example: Laboratories are found jerked from walls and toilets are found stopped with beer cans, socks and other assorted objects. In such instances the crew leader and owner are contacted and conferences held to tighten up supervision and see that all crew members are made to understand the severity of the problems and to take steps to eliminate such conditions.

Campsite:

Continuous emphasis is made to the crew leader and his wife (if present) on the necessity of proper maintenance of facilities and the promotion of cleanliness of the premises. This includes proper garbage storage and disposal and policing of the grounds.

General:

Complaint items in areas of premises whose inhabitants are predominately migrant are referred to the project sanitarian. These may include complaints that "dirty" migrants are in a previously non-migrant residential area. A complaint investigation is made with explanation to neighbors regarding housing shortage and request for cooperation. Frequent meetings and conferences are held in areas where confusing conflicts may arise; i.e. Florida State Hotel and Restaurant Commission, Building Department, Substandard Housing Inspector, interested property owners, Housing Director for District Community Action Fund and other interested civic and official groups.

Types of Individuals and Groups with whom working relationships were established and purposes of relationships

Florida Hotel and Restaurant Commission:

Discussion and coordination of joint efforts to upgrade conditions by enforcement of prescribed standards in dwelling units that may be under such supervision.

Fire Departments:

Joint pre-licensing fire insepctions of camps with recommendations and continuing advice to camp owners.

Agricultural Experiment Station, Palmetto:

Information and Data regarding crops, yield, farmer problems, etc.

Community Action Fund (OEO):

Continuing conferences and coordination to improve working and living conditions of migrants with special emphasis presently being placed upon housing in areas outside camps.

County Building and Zoning Department:

Coordination and development of rules and criteria for the betterment of migrant sanitation and living conditions as pertains to plumbing, structural details of housing, zoning, etc.

Orientation and In-Service Training of Staff:

Attendance of health conferences (area wide) on Migrant Health and related problems. Attendance at migrant oriented meetings of Florida Christian Ministry. Attendance of joint migrant oriented meetings on convention level. Sanitarian attended weekly general sanitation staff meetings in Health Department where problems interrelating to general sanitation and migrant sanitation were discussed. The Sanitarian participates in and belongs to a national sanitation organization.

Problems which prevent proper maintenance of facilities

The general disrespect for property rights among the migrants seems to be the primary problem which hinders or prevents proper facility maintenance.

Drunkenness and vandalism are rampant. Wanton destruction of windows, screens and sanitary facilities on a recurring basis of approximately once a week at least, has so incensed the growers that a feeling of disgust may well have grown toward all the migrants. Conferences with the growers and crew leaders with a view to closer supervision have led to some general improvements. The migrants seem to possess a vast indifference to the excess use of water, electricity, etc. In some instances, however, a happy state of affairs has been reached where a grower will construct a good camp for a responsible crew leader with a good crew. Then, a surprisingly small amount of damage is done.

Problems which prevent growers from making improvements

Farmers and growers are adverse to spending money in large sums on an operation which is of short duration and becomes acute for only about two months of a year. During the period between crops most of the growers feel that they have plenty of time to make necessary repairs prior to next season. Then, as of overnight, they find themselves caught up in a myriad of problems pertaining to the crops themselves and whether or not the expenses will exceed the "norm." It is in the midst of this worrying that they are called upon to devote some of their time and resources to building or repairing migrant quarters. The large operations are still generally a "one-man" affair as applied to the overall effort. It is safe to say that procrastination and the hesitance to spend cash before it is absolutely necessary on other than the crop itself, are the biggest factors which prevent growers from making improvements.

A killing freeze in January of the current year necessitated a nearly complete replanting of tomatoes in Manatee County. The resulting cost and worry, without doubt, had an adverse effect on projected improvements.

Problems preventing migrants from maintaining facilities

It is believed that the drabness of the labor camps is one of the primary reasons for the discontent which leads to poorly maintained facilities. Even at inception, most camps do not lend themselves for a comfortable degree of living nor do they engender any spark of pride in the persons living in them. Privacy is at a premium, fixtures such as clothes hangers, storage space, etc. are generally primitive and inadequate. The majority of migrants suffer under the title of "vandals" based on the actions of a relatively small minority. General kitchen facilities for large number of families have been found to be unsatisfactory. Due to relative time limitations and relative small food budgets, coupled with large family groups, the food is prepared in their quarters and tends to attract insects and make for insanitary conditions. A close study of the family feeding setup with a view to correcting the above deficiencies should materially alleviate a bad condition. Most of the problems preventing the migrants from maintaining facilities are not of the migrants making but are due to a poor projection of the camp's use at its inception. Invariably, a camp will be overcrowded at some time during the "season" to such a degree that personal sanitation is of secondary consideration.

Other problems

It is increasingly difficult for project staff to correlate field activities with specific camps, growers and crew leaders. There seems to be a growing tendency for crew leaders from other counties to pick up and deliver workers, even in the heart of Manatee County, for only one or two days then maybe next week move to another field or even another area. There appears to be, at least during the current "season", a marked trend toward "floating" groups. The problem posed by individual groups "squatting" in a substandard vacant house has been materially remedied with the cooperation of the County Building Department Substandard Building Inspector. At least fifteen (15) houses so used by migrants have been "posted" during their absence "up the road."

General appraisal of results of sanitation service regarding:

"Migrant Understanding and acceptance of responsibility for improvement of their own practices in the use of housing and field facilities.

The average migrant is usually adverse to accepting responsibility, however, it has been noted that where conditions permit (such as in new camps with adequate facilities) a surprising number show the beginnings of a degree of responsibility not evidenced before. This is especially true where the individual migrant or migrant family has separate facilities. The "singles" or "floaters" seem to be the prime trouble makers. Family groups seem to accept more responsibility.

"Camp and other owners acceptance of responsibility for providing and maintaining facilities in an acceptable way."

Growers, as a group, still feel that the necessity for providing adequate facilities is a burden and a nuisance, but through personal conferences and "missionary" work are beginning to realize the correlation between better facilities, better workers, less damage and more profit.

"Community understanding of the situation, relationships and attitudes."

Much publicity has been given to the migrant situation in the project area, but the majority is biased depending upon the writer. The general attitude is that the migrants are a necessary nuisance and even civic groups (not intentionally) stress what must be done for the migrant and how it shall be done rather than making for a more general acceptance of the migrant as simply "poor people with wheels." This is no doubt due both to nationwide publicity and to the number of persons engaged in migrant allied endeavors. However, more people are giving the matter of acceptance more thought than ever before.

"Grower-Migrant relationship, willingness of migrants to stay throughout the season, etc."

In the camp area, the same crews return year after year to the same camps. The crews generally remain for the full season. There was very little defection while there was work to be done in the 1965 Spring Crop Season, but due to the short, harassed (approximately 6 weeks) season this year, it was noted that there was a noticeable amount of leaving and "trading around" among the migrants. Some few crews left early due to prior commitments further "up the road."

"Disease conditions attributable to poor housing and sanitation."

This has been impossible to evaluate due to the fact that no outbreak of any kind was reported in the camps and also due to the fact that probably many cases of illness were unreported. A strong child immunization program for migrant children was carried on in this project area.

General Appraisal of Adequacy of Services

All labor camps in the project were visited several times during the course of the project period. Overall, complete inspections were made with necessary follow-up. Deficiencies noted were discussed with the respective crew leaders and/or owners. In general, compliance with regulations and willingness to cooperate were gratifying.

No overall program of "other than camp" housing was in effect. Further effort needs to be directed to this phase of the project. Adequate housing both as to physical numbers and space is a prime problem which must be studied and resolved.

This project does not have a mobile clinic program nor are migrants sent to local doctors with the project paying part of or all of the medical fees incurred.

Health education for growers, crew leaders, and migrants was of a cursory nature due to the time limitations placed on one sanitarian. Our project does not have a Health Educator.

Other information and suggestions

It is our feeling that adequate, good housing is the primary problem facing those who would better the migrant's living conditions and standards. The major drawback to adequate housing, both camps and other, is the short-term occupancy of the tenants. It is felt that the camp sanitation picture would be much brighter if strong resident supervision were put in each camp with a concrete standard of sanitation to be strictly adhered to. Every effort should be made to put all camps on central waste water treatment system and do away with existing individual septic tanks and privies. More study should be directed toward usage of approved portable toilets for better field sanitation. Further work and effort should be directed to the creation of understanding and good will between labor and management.

ORANGE COUNTY HEALTH DEPARTMENT

Wilfred N. Sisk, M. D., Director

Area of County: 916 square miles

Resident Population: 297,000

Number of Migrants: 10,000

Migrant Project Staff; 3 Public Health Nurses
2 Sanitarians

ANNUAL PROGRESS REPORT

MIGRANT PROJECT

ORANGE COUNTY, FLORIDA

The year 1965-66 showed a considerable increase in this department's migrant facility inspection and migrant education efforts.

The charts included in this report will reflect the efforts made to increase the benefits to good sanitary procedures and practices.

Migrant living areas have undergone a change in the last few years in Orange County. There seems to be less concentration in defined areas and more indications of scattering through the low-rent areas of the County.

Labor camp use has continued to decline and we expect this trend to become the rule.

Two sanitarian's time and efforts are reflected in our reports but many of the division's personnel are active in this program.

Investigation of complaints that are made to this department concerning sanitation conditions in areas that could be migrant housing account for a considerable portion of time spent on migrant work.

1. Staff

Two sanitarians 100% of the time.

2. Location of camps within project area.

Western and Northwestern parts of County.

3. Laws, regulations, or other criteria for evaluating camps.

Florida State Board of Health Camp Regulations.

4. Number of camps in area by size and type of occupancy.

Seven Labor Camps. Operation seasonal, depending on fruit and vegetable season and off-shore labor. Size range from 50 to 600 capacity. All migrant single laborers, no families.

5. Sanitation services related to camps.

Camp Visits	51
Camps Visited	5
Number Meeting Standards Beginning of Season	5
Number Brought up to Standard	0
Number of Meeting Standards at End of Season	5
Number of Defects Found	60
Number of Defects Corrected	33

6. Other types of housing used by migrants moving into project area or leaving it temporarily for seasonal work in crops, by type of housing, major locations, and estimated number of persons housed at each major location.

Migrants inhabit numerous rental units in the West and Northwest areas, scattered through low-income housing areas.

Approximate during season:	Winter Garden.....	150
	Ocoee.............	50
	Plymouth..........	100
	Zellwood..........	100
	Apopka............	200

7. Laws, regulations or other criteria for evaluating housing not located in camps.

The Sanitary Code regulations regarding public and private housing are the rules followed and enforced, where applicable.

8. Sanitation Services Related to Migrant Housing Outside Camps.

Number of Visits Made	2,062
Number of Locations Visited	251
Number of Housing Units Visited	50
Number of Units Meeting Standards Beginning of Season	50
Number of Housing Units Brought up to Standard	0
No. of Housing Units Meeting Standards end of Season	50
Number of Defects Found	605
Number of Defects Corrected	298

Sanitation Services and Inspections Related to Migrant Housing Outside of Camps.

Private Water Plants	7
Public Sewerage Systems	45
New Septic Tanks Installed (Spec.)	32
Percolation and Soil Log Test	19
Schools	16
Mobile Home Parks	23
Eating & Drinking Establishments (26 Establishments Visited)	215
Food Processing Plants	23
Grocery and Meat Markets	381

9. Number of field locations visited during crop season compared with estimate of total number of field locations where migrants are employed.

Field Locations	21
Estimate	85

Total number of field visits concerned with field sanitation made throughout season.

Field Sanitation	15

10. Number of field locations by source of water supply used for drinking water; for handwashing.

Water supplies in field consist mainly of portable drinking water containers.

11. Number of field locations by method of waste disposal.

Waste disposal in field is usually by portable privies, but not on all locations. Some still lack facilities.

12. Laws, regulations or other criteria used in evaluating field sanitation.

Temporary privy regulations.
Sanitary water service.
Florida State Sanitary Code.

13. through 17.

Educational efforts are planned for next migrant season. This season was devoted to attempted correction of defects in housing and camps. Individual educational sessions by nurses and sanitarians in the field were routinely accomplished.

18. Problems which prevent or hinder growers (or other owners) in making improvements in housing and field sanitation; ways in which problems have been met; reasons, if no way to meet problems can be identified.

Lack of public water and sewage facilities in migrant areas is one of the biggest problems. Establishment of sanitary districts would be one method of correction. Individual disposal systems always present maintenance and operation problems. Lack of education in basic sanitary practices and unusual lack of responsibility (destroy fixtures) on the part of the migrant population.

19. General appraisal of results of sanitation service.

Migrants generally lack responsibility for other property and do not accept educational advances. Owners get discouraged when they must constantly replace and correct basic sanitary facilities. Community shows general apathy toward migrants. Pay scale and housing determine lengths of stay in season.

20. General appraisal of adequacy of services.

All camps were served by sanitarians. Corrections in private housing areas were difficult because of local law problems. Health education emphasis is to be increased next season.

21. Specific information and suggestions based on this season's experience that would be helpful in future operation of this project, or helpful to others in planning housing or field sanitation programs in knowing what to plan for, and how to conduct a program.

Emphasis placed on education in the housing areas through films and handouts on basic sanitary appliances and practices would increase the efficiency of program.

PROJECT OBJECTIVES FOR ORANGE COUNTY

The objectives for the past year of service to the migrants, as far as health services are concerned, was slow in getting started but quite well fulfilled and gratifying as the year's work is reviewed.

The clinics set up in Winter Garden have been well attended by the migrant population and the clinic in Apopka was moved from the central area of Apopka to a small community known as Zellwood amidst the migrant housing area. Clinic hours were changed to the evenings and additional staff, along with the two migrant nurses, had to be put into these clinical areas to work due to the patient load and complete screening each patient received. A retired physician treats our migrant patients since he only desired part-time work. He does an excellent job in the morbidity clinics. In the other general clinics attended by migrants, resident physicians from the local hospital and the Assistant Health Officer see the patients. A Gyn physician does all of the IUD's.

A record system has been developed in Orange County but there is some revision and improvement yet to be done.

The people working on this Migrant Program, though it has been difficult in many ways, have found it to be a very gratifying service. The main problem is finding adequate personnel to staff the clinics as the project people cannot carry the clinic load or necessary follow-up themselves. The Sheriff's Department has been very courteous in patrolling at the night clinics since they are located far from the town.

ANNUAL MIGRANT PROJECT REPORT

NURSING AND MEDICAL, March 1, 1965 through March 31, 1966 - FAMILY HEALTH SERVICES

Type of Clinic	Sessions		Hours in Clinic		Patient Visits
	MD	PHN	MD	PHN	
Morbidity	101	101	256½	Not Broken Down	
Others where attendance was over 50% migrants as, Maternity, Child Health Conference, Immunization, TB and VD	329	514	508		
Total Patient Attendance					2380
Return Visit Attendance					1805
Total	430	615	764½	1,538	

Most clinics in outlying offices of Apopka, Winter Garden, and Winter Park where migrant attendance is high are generalized combination clinics serving all family members and physical requests. Thus, maternity, immunization, child health conference, TB, VD, are all seen in one day and the clinic operates as a general practitioner's office. We have found this conversion a little confusing at first, but time saving and beneficial to families in saving repeat visits.

Physicians services to patients......	1767
Nursing services to patients only....	2380
Those receiving medication or........ treatment including immunizations	1917

Since adding evening and late afternoon morbidity clinics for the migrants our clinical case load has increased. Exactly how much it is difficult to say as we did not really get our evening clinic going until the middle of February, 1966. These are our Zellwood and Winter Garden clinics.

The Winter Garden clinics are held in our Winter Garden office and the patient response is good even though some migrants have two or three miles to travel.

The Zellwood clinic is held in an old barracks building in a migrant housing area and the patient response at first was quite slow in picking up, but by the end of the season was good.

Since many of the migrants in Orange County leave the mothers and children behind while they work somewhere else, we felt a need for keeping our migrant clinics open all summer but will change the clinic time to the afternoon hours.

TABLE I is attached to show our clinic response according to age groups, ethnic groups and sex.

TABLE II shows the major conditions of migrants requiring care. Error was made in not starting from the beginning and categorizing major conditions according to age, ethnic group and sex. We have started this for our second year of the Migrant Program.

There are approximately 10,000 migrants in Orange County; one-third of them being actual workers - about 3,000 migrant (actual) farm workers. In working with the migrants for the past year, we have found many of the women and children remain in Orange County during the summer and early fall months while the male breadwinners continue to migrate.

The date of arrival and departure of the migrants still remains irregular, though the largest numbers arrive in the latter part of September until November and remain until about April 1. Some migrants, we have recently learned, migrate around the States of Florida and Georgia and no longer follow the migrant stream to the northern and western states.

The migrant families continue to live in all parts of Orange County, in poor housing areas, the largest number being Negro.

During the 1965-66 season about 500 home visits were made by Public Health Nurses . . . Two Public Health Nurses assume the main responsibility for care to the migrants. Along with these nurses, five other staff nurses (not assigned to the Migrant Project) assist with care to the migrants. One nurse donates about 100% of her time. In addition, one Public Health Nursing Field Supervisor, Nursing Director, three Clinic Aides, two office clerks and one stenographer give much assistance to the Migrant Program.

Complete screening is offered in all of the migrant morbidity clinics, including blood pressure, serology, blood sugar or dextro-stix testing for B.S., PPD testing, immunizations, Pap smears, pelvic examinations, physical examinations and X-rays upon physician's request (as the X-ray unit is in the main office and not in the outlying areas).

Nutrition and health education is given to the best of the Public Health Nurse's ability, using audio-visual aids, diagrams and leaflets, for relating facts concerning immunizations, planned parenthood, communicable diseases, good health and hygiene habits.

A Headstart Group, non-related to the School Board, has set up some nursery schools throughout Orange County, many of which are in our migrant areas. The only problems arising were:

(1) A Public Health Nurse staffing on this private Headstart Program.
(2) The group's moving into churches that we had been using for Immunization and Child Health Conference Clinics making it necessary to close the clinics or find other quarters. Three clinics had to be closed until Headstart is over - Tildenville, Avalon and Zellwood. All of these serviced mostly migrants.

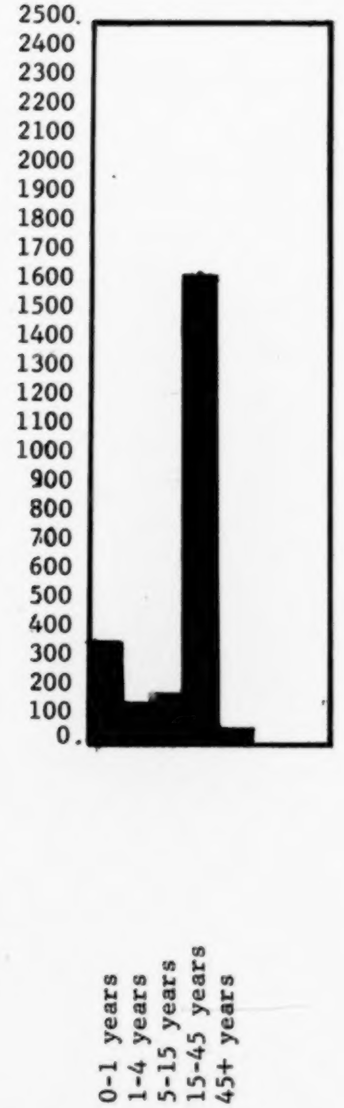
The Migrant Ministry has been assisting Public Health Personnel in the clinics on a voluntary basis. A short course on clinic procedure and intake of patients was given by the Nursing Director of Orange County Health Department to these volunteers, which has proven quite profitable in assisting the nurses.

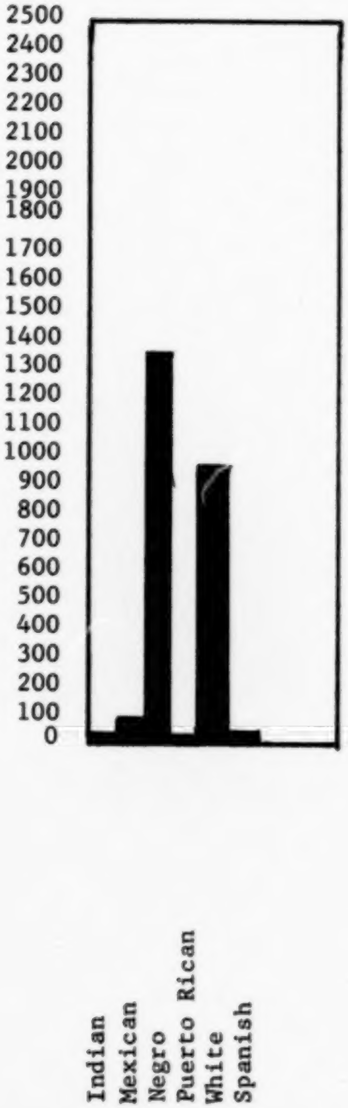
TABLE I

AGE GROUPS OF MIGRANTS RECEIVING FAMILY HEALTH SERVICES	
0 - 1 years	346
1 - 4 years	177
5 -15 years	192
15 -45 years	1630
45+ years	35
	2380

ETHNIC GROUPS	
Indian	5
Mexican	68
Negro	1354
Puerto Rican	2
White	934
Spanish	17
	2380

SEX	
Males	450
Females	1930
	2380





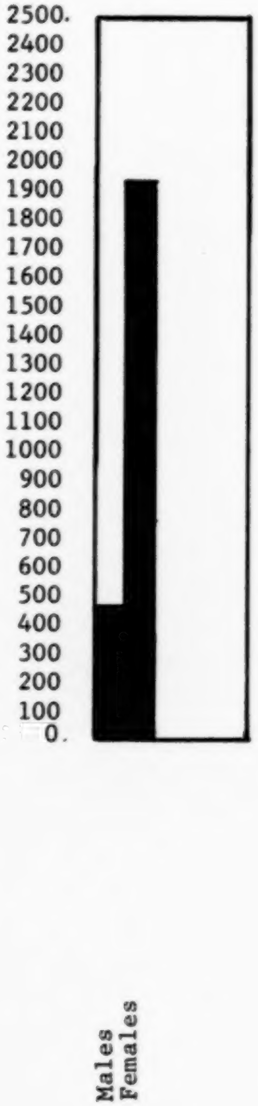
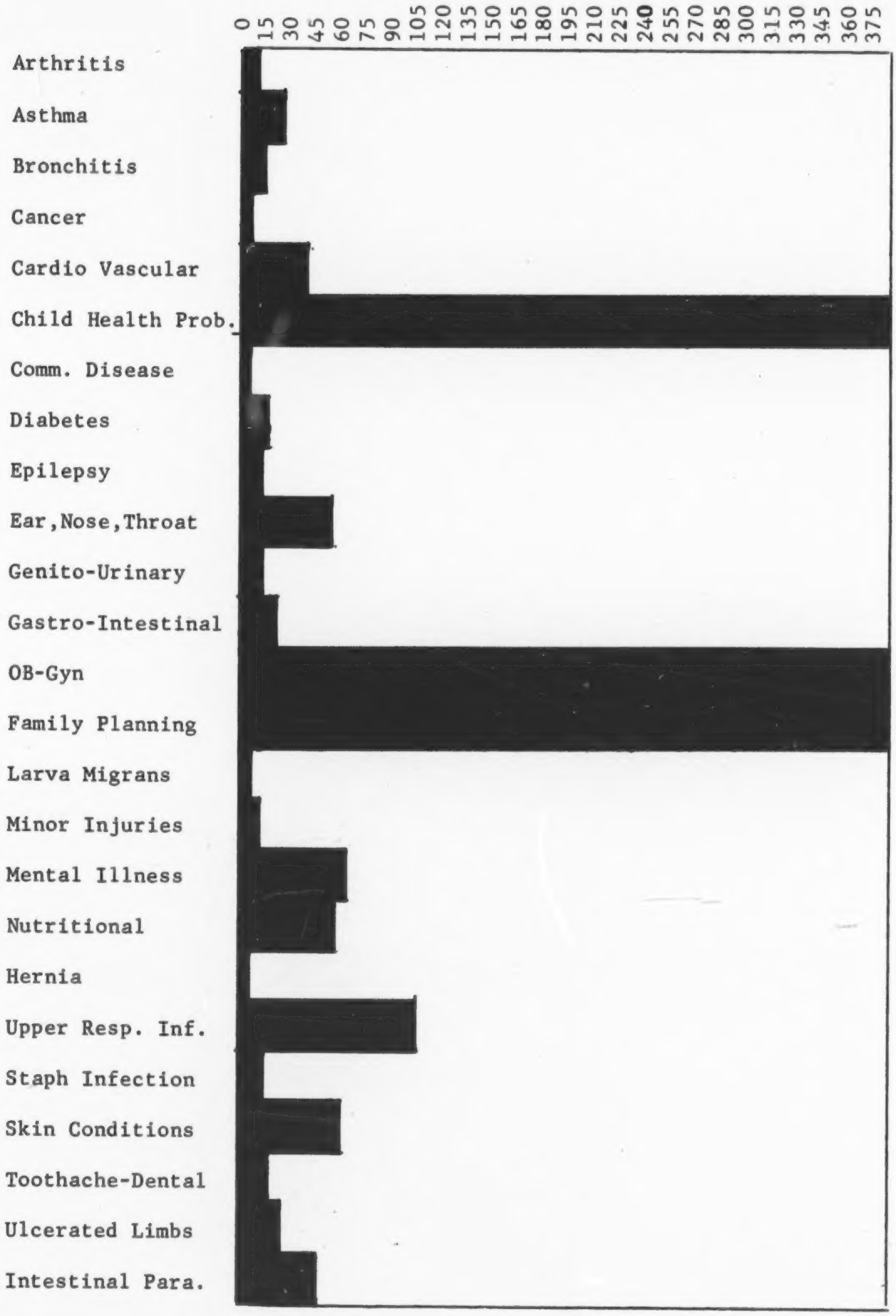


TABLE II - MAJOR CONDITIONS OF MIGRANTS REQUIRING CARE
(By Number of Persons)



IMMUNIZATIONS COMPLETED ON MIGRANTS

March 1, 1965 through March 31, 1966

TABLE III

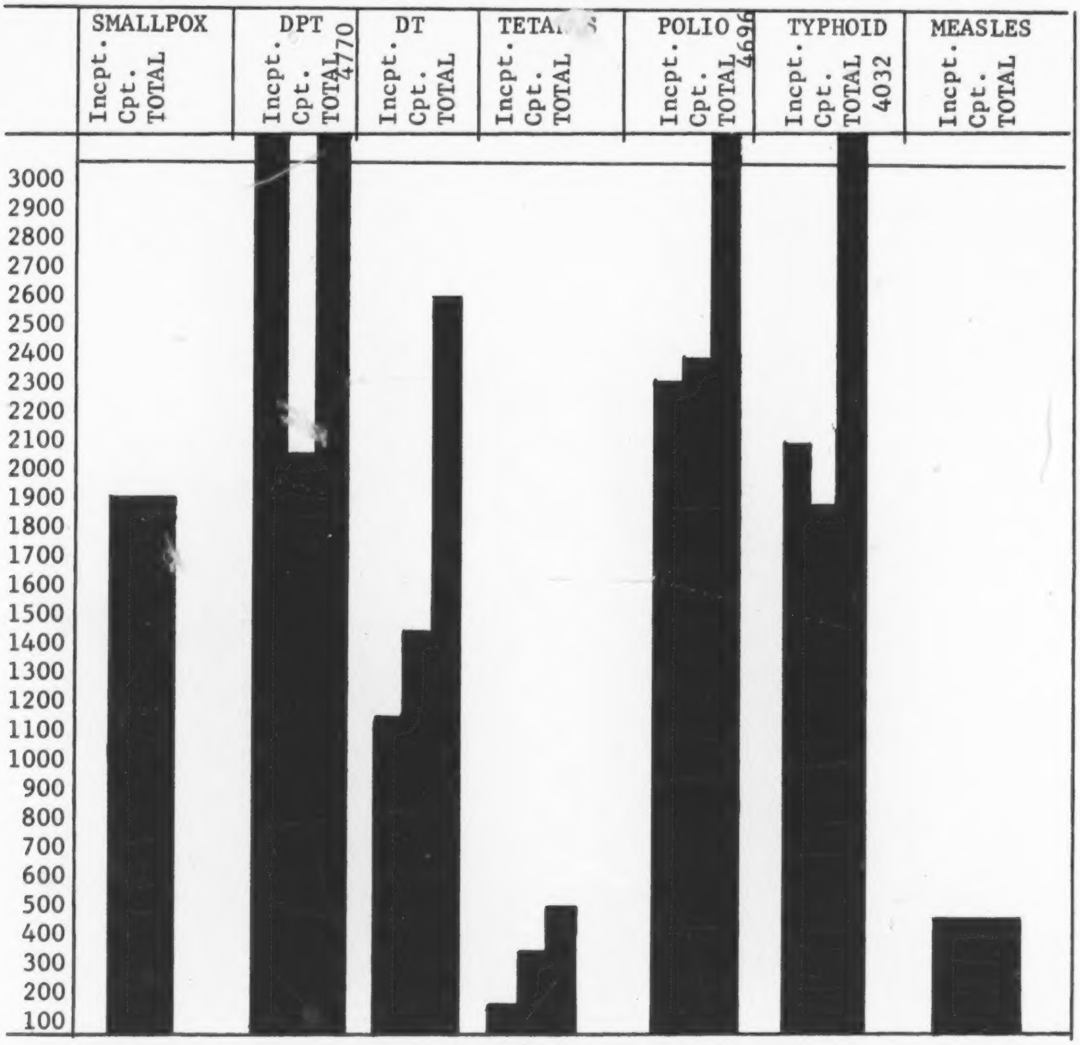


TABLE IV

IMMUNIZATIONS
March 1, 1965 through March 31, 1966

	-1 Year	1-4 Years	5 Years & Over	Boosters & Revaccination	TOTAL's
SMALLPOX					
Incomplete	0	0	0	0	0
Complete	449	510	313	654	1926
TOTAL	449	510	313	654	1926
DPT					
Incomplete	1289	1270	428	0	2987
Complete	544	424	183	932	2083
TOTAL	1833	1694	611	932	4770
DT					
Incomplete	44	490	645	0	1179
Complete	15	146	602	675	1438
TOTAL	59	636	1247	675	2617
TETANUS					
Incomplete	5	34	96	0	135
Complete	0	31	279	76	386
TOTAL	5	65	375	76	521
POLIO					
Incomplete	158	1004	1156	0	2318
Complete	156	666	1374	182	2378
TOTAL	314	1670	2530	182	4695
TYPHOID					
Incomplete	128	875	1125	0	2128
Complete	66	348	742	748	1904
TOTAL	194	1223	1867	748	4032
MEASLES					
Incomplete	0	0	0	0	0
Complete	50	207	69	158	484
TOTAL	50	207	69	158	484

FAMILY HEALTH SERVICE OBJECTIVES - 1966-67

(1) To continue to improve the comprehensive medical services already in existance for migrants, with greater emphasis and follow-up on family planning, good nutrition and health hygiene during pre-natal and post-partum periods, a high risk maternity clinic, continuous emphasis on immunizations (especially measles, which is quite low in comparison to others) and child health problems and health supervision. More Public Health Nursing visits to migrants as well as hospitalization.

To employ a full-time Clinic Aide to assist the three Public Health Nurses and the part-time physician, who works on a fee basis.

(2) To continue to improve health education and nutrition services.

(3) To continue to inform the staff, general public, other agencies and civic clubs of the services and project aims for the migrants.

(4) To continue the existing relationship with the Migrant Ministry and the useage of their volunteer ladies in the clinics.

(5) To attempt to get any other projects in the community interested in the migrants to work more closely with the health department so programs can be planned without overlapping of services or stepping on other's toes by pushing existing clinics and programs out.

ANNUAL MIGRANT FAMILY HEALTH SERVICE REPORT ON WHICH NARRATIVE, GRAPHS AND OBJECTIVES ARE BASED

	March 1, 1965 through March 31, 1966				
	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	TOTAL
Clinic Sessions					
Morbidity	22	27	27	25	101
Other Clinics	34	43	75	76	228
Total all Clinics	56	70	102	101	329
Clinic Session Hours					
Migrant Physician	49	54	76	77½	256½
Other Physician hours	68	86	150	204	508
for non-morbidity cl.	--	--	---	---	---
Total Phys. Cl. Hours	117	140	226	281½	764½
PHN Clinic Hours	129½	280	244	884½	1538
Attendance					
Total Attendance	221	694	607	858	2380
Return visit Attend.	165	567	444	629	1805
New Patients	---	---	---	225	225
Sex					
Males	48	91	45	186	450
Females	173	593	492	672	1930
					2380

(Continued on next page)

(Continued)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	TOTAL
Age Group					
0-1 Years of Age	30	85	96	135	345
1-4 Years of Age	16	28	61	72	177
5-15 Years of Age	14	37	37	101	192
15-45 Years of Age	158	508	430	534	1630
45 & Over "	9	7	3	16	35
					2380
Ethnic Groups					
Indian	--	1	2	2	5
Mexican	15	8	15	30	68
Negro	117	421	342	474	1354
Puerto Rican	--	--	--	2	2
White	87	264	249	334	934
Spanish	1	--	--	16	17
					2380
Services Given					
Exam. by Physician & Nurse	192	460	464	651	1767
Nursing Visit Only	221	694	607	858	2380
Left Before Seen	--	--	--	1	1
Medication or Treat.	62	479	592	784	1917
Referrals					
Sunland	--	--	--	1	1
Florida Council for The Blind	--	--	--	2	2
Florida Crippled Child. Comm.	3	--	--	2	5
Local Hospital	1	1	--	6	8
Private Med. Phys.	--	3	--	--	3
Tumor Clinic	--	3	--	--	3
Physician's Diagnosis					
Bronchitis-Acute	2	--	--	7	9
Cancer	--	--	--	4	4
Cardio Vascular	6	12	7	13	38
Child Health Prob.	48	135	165	279	627
Comm. Disease	2	1	--	1	4
Chronic Disease	--	7	10	3	20
Diabetes	--	1	2	4	7
Genito-Urinary	2	--	--	7	9
Gastro-Intestinal	--	--	2	14	16
Intest. Parasites	1	4	13	24	42
Family Planning	--	389	101	183	673
OB-Gyn	136	--	307	308	751
Upper Resp. Infect.	2	--	15	78	95
Staph Infections	5	--	--	--	5
Skin Infections	7	--	6	41	54
Ulcerated Limbs	8	--	--	6	14

(Continued on next page)

(Continued)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	TOTAL
Minor Injuries	7	--	--	2	9
Asthma	--	--	--	16	16
Venereal Dis.	3	12	15	26	56
E,E,N,T	2	--	--	41	43
Larva Migrans	--	--	1	--	1
Toothache-Dental problem	--	--	--	7	7
Mental Illness	11	13	11	1	36
Anxiety Syndrome	2	--	--	10	12
Nervousness	--	--	1	1	2
Arthritis	--	2	--	4	6
Nutritional Dis. & Anemia	3	--	2	45	50
Hernia	--	--	2	1	3
Tuberculosis	2	24	7	19	52
Epilepsy	2	--	--	3	5

POLK COUNTY HEALTH DEPARTMENT

James F. Cason, M. D., Director

Area of County: 1,861 square miles

Resident Population: 212,000

Number of Migrants: 20,000

Migrant Project Staff: 2 Public Health Nurses
1 Sanitarian

MIGRANT PROGRAM

HEALTH EDUCATION SERVICES

I. STAFF

During the 1965-66 report period Polk County's only health educator increased health education services to migrant farm workers but as the area of the county is large and the migrant families and workers are interspersed throughout the general population, health educational activities to this selected group have been quite limited. Opportunities for health education are tremendous and if another health educator could be employed, much more could be accomplished for the benefit of these nonpermanent citizens. One area of need is to help the adults learn where to find local resources such as thrift clothing stores, health clinics, federal donated food supplies, etc. Other areas of need involve money management, nutrition and family planning.

One of the primary factors of the educational program has been the continuing efforts of the public health nurses and the sanitarians to create a strong health education program for all indigent groups which include the migratory farm workers and their families. In addition to these disciplines, other groups have been contacted for voluntary services.

II. SERVICES

Audio-visual aids and easily understood educational materials were ordered for use with migrants. These materials were distributed to clinics, schools and homes. Venereal disease literature was distributed to parent and student groups in an area where there was an outbreak of syphilis. A Negro school principal said that she thought some migratory citrus workers were bringing venereal disease into this community. Approximately thirty (30) adolescents were named as contacts in this outbreak. As a result of this outbreak the county public schools began an educational program at the junior high level. Several conferences and meetings were held with members of the Polk County Association of the Florida Christian Migrant Ministry. Through these meetings this group became aware of the services provided by the health department and the members were helpful in providing transportation for the women and children to the clinics. The film, "The Season People," was shown to the group.

The health educator also showed the State Board of Health's film about Florida's migrants to the county's Home Extension Home Economists and to women's civic and professional groups. The health educator attended a planning meeting at the Polk County School Board offices on increased vocational services for migratory workers.

One effective innovation of the program was the development of health education sound tapes with the cooperation of the Mid-State Tuberculosis and Respiratory Disease Association, public health nurses and the health educator. These recordings are played regularly in the reception rooms at the health clinics to provide an educational experience for the patients who are waiting for clinic services. There have been many favorable comments by the patients. If a carrousel projector were available and synchronized with the sound, prenatal and child care advice could be given. Slides have already been produced showing local situations and educational pictures for prenatal patients. The department needs funds for this type of projector.

A health education film on hookworm was shown at several schools that have many children from migrant families. Take-home literature on hookworm was distributed.

Three films that the U. S. Public Health Service produced especially for migrants were purchased and shown to members of the health department staff for use at clinics and with groups of migrants.

The health educator and public health staff assisted in an educational program to encourage adult women to have a uterine examination for cancer. This was done through the cooperation of the American Cancer Society. An article was published in the county physicians monthly bulletin to inform the local physicians that this service is available for indigent patients at the health clinics. Films were shown and exhibits with literature were set up at the clinics.

The health department staff assisted in an intensive health education program in the Eloise area when a rabid puppy was brought into this community by an out-of-state migratory family. Ten news releases were published by newspapers and every county radio station received information. Copies of news stories are attached. The families and neighbors involved were immediately gathered at the Winter Haven Health Center, through personal contact by the nurses and sanitarians, for a meeting to inform them of the need for medical treatment. The health educator interviewed the owners of the dog.

A meeting of the administrative staff of the Health Department and the County Hospital was held for the purpose of planning the coordination of medical services to migrant non-resident persons.

III. APPRAISAL

The health educator has found the community to be interested in the problems of the seasonal farm worker becuase these workers are an asset to the economy of this county. Many of the workers consider Polk County "home base" and work hard to provide the necessities of life for themselves and their families. While it is true that some employers find that the workers will not work full-time, many realize that the back-breaking work of moving ladders, climbing trees and picking fruit is physically exhausting.

The migrant persons who have been contacted can be motivated to improve their lot and educational methods can be used to meet the health needs of these patients who do not read or write. The health educator considers the program worthwhile and believes that funds for employing another health educator, literature for family planning and venereal disease control and a carrousel projector would be both a wise investment and beneficial to the Migrant Program in Polk County.

> and/or have money to pay for service. This group is often responsible for creating social problems of all kinds within the resident population as well as other migrant groups. Members of this group are in real distress if they become ill or cannot find employment readily.

The Migrant Health Program as carried on by the Health Department has helped only a few of this last category. Because they are so scattered we have little real knowledge of who or where they are or how to effectively reach them. Our usual contact with them is through their involvement with some other individual or problem we have worked with or when an emergency exists and we are called upon for assistance.

On the other hand we feel we have been able to greatly increase and improve services to the first two groups. Additional staff has stimulated greater consciousness of migrants' needs by all staff members; with additional nursing time a higher priority for service has been assigned them, but perhaps the greatest improvement in service has been due to the availability of medicines, supplies and equipment. The availability of these materials have made it possible to treat some illnesses in clinics that were completely neglected or referred elsewhere with uncertain knowledge of service actually received. The length of time patients are required to wait for service has been reduced by the use of disposable equipment and other equipment in adequate amounts. An example of such a saving involves the use of two portable bassinetts in one of the large clinics. Their use has freed one clinic aide who used to spend most of her time during clinics holding babies while their mothers were receiving service. Very few cases of malnutrition are now being seen in our clinics due to the steady supply of vitamins and iron that are routinely furnished for mothers and babies. We have also been able to supply milk to infants and young children in families receiving inadequate amounts.

Perhaps some of our best services to these people were not planned as a part of the program but have come about incidentally as contacts have been more numerous, communications improved and interest stimulated. Examples are:

> Receipts showing payment on accounts of any kind are accepted as proof of residence by agencies with a residency requirement;
>
> A record of physical examination and immunization done in the health department assures a child's entry to school although he may not yet have proof of birth which is also required and more difficult to obtain;
>
> Rent receipts are accepted as proof of residence even though the house may have been unoccupied;
>
> Families may apply for food commodities even before the wage earner leaves so that applications are processed before the necessity for food arises;
>
> Health services seem to be made available in other parts of the country when we direct our clients to make it known elsewhere that they have received care in our department. (We do not have any explanation as to why this happens but the experience has been related to us frequently by clients.).

MIGRANT PROGRAM REPORT

May 1, 1965 to April 31, 1966

DIVISION OF NURSING

Participating in the Migrant Health Program for the past one-and-a-half years has given our staff an opportunity to more clearly define this group of people and to recognize their component sub-groups and the different problems associated with providing health services for each.

Our original estimate of a migrant population of 20,000 persons appears to be essentially correct. From several sources, namely our own Public Health Nurses, the personnel managers of five (5) large citrus growers, the principals of eight (8) large elementary schools, the Winter Haven office of the State Employment Agency and the Social Service Department of the County Hospital, we have gathered information that is useful in evaluating the program thus far as well as in planning for continuation of the program.

the 20,000 persons classified as Migrants by the United States Public Health Service definition are subdivided as follows:

> Approximately 15,000, including men, women and children, have social and more often than not, financial ties to this county. These include those families in which the father and frequently adolescent children go north in the summer to work in the harvest. They often own property and definitely consider this their home. Their wives sometimes take the small children and spend a few weeks with relatives living on farms in Georgia, Alabama and Arkansas. However, their residence status within the county is usually maintained. They are regular clients of all Health Department services and more often than not, can name a physician they go to in case of illness. Most general practitioners care for these families and consider them part of their patient load knowing that they are to some extent a financial risk. Because they maintain ties here they can generally obtain hospitalization if this is needed.
>
> The second group, made up of approximately 3,000 persons are referred to by growers as "the steady pickers." This group is primarily men who return to this same area year after year and often to the same employer. Some are married and have young children. Until the children are of school age the wife and children either travel with them or follow them when work is located elsewhere. This group generally does not meet the residency requirement for County Hospital services although they can usually obtain medical care from private physicians by having their employer make contacts or vouch for payment. They are usually regular clients of the Health Department clinic services.
>
> The third group of about 2,000 are the "hard core" migrant workers nearly all of whom are single men who have few if any social ties, no credit rating and do not qualify for health services of any kind except in Health Department clinics or County Hospital emergency rooms. Most physicians will care for them if they are seriously ill

The first additional nurse employed with Migrant Program funds was put on the payroll December 14, 1964; the second on May 1, 1965.

From the beginning of their service they have been assigned to a generalized program serving all population within a geographical area. At the same time all other staff nurses were asked to identify the migrants they worked with according to the service rendered.

The following table reflects the percentage of services given to migrants as compared to those given to all clients. In most instances it may be noted that the percentage of visits is greater than the percentage of admissions for an individual category of activity, thus showing the greater attention this group of the population received.

It may also be noted that while the time of two nurses during any given month is only 4.65% of our total nursing staff, the percentage of patient admissions, visits and consequently time, is equal to this in nearly all instances, in most it is double and in some instances it is as much as four times as great.

Forty-three (43) nurses on staff
Two (2) nurses furnished by Migrant Program or 4.65%.

	TOTAL	MIGRANT	PERCENT
Communicable Disease Control Admissions	232	8	.03%
Visits	457	64	14.00%
Treatment for Parasites	924	41	4.43%
Patients treated for Venereal Disease	832	17	2.04%
New active cases of Tuberculosis admitted, investigated and given care	93	7	7.52%
Immunization series completed (all types)	45,648	7,620	16.69%
Patients admitted to Maternity Medical Service	1,528	122	7.98%
Post partum medical examinations including Pap smears	834	90	10.79%
Number Pap smears followed as suspicious of CA	42	2	4.76%
Patients admitted to Maternity Nursing Service	1,880	178	9.05%
Nursing Visits	11,942	1,176	9.84%
Patients admitted and furnished contraceptive materials	1,358	138	10.16%
Children admitted to medical services	1,246	253	20.30%

CONTINUED	TOTAL	MIGRANT	PERCENT
Children given medical examination and care	2,262	343	15.16%
Children admitted to nursing service	8,482	548	6.46%
nursing visits	22,217	1,840	8.28%
Admitted to adult acute morbidity service	1,058	124	11.72%
Visits for adult acute morbidity nursing	1,815	223	12.28%
Patients admitted to diabetic nursing care	315	8	2.53%
Patients admitted to cardiac nursing care	287	11	2.84%

A multiphasic screening project was organized as a joint project of a unit of the Christian Migrant Ministry and Health Department personnel. Eighteen (18) volunteers were used in a house-to-house canvas to publicize the clinic, evening hours were set, a facility was found in the center of the community, two (2) interpreters were recruited since some of the people were Spanish speaking. Of the 400 possible participants, 103 attended the clinic. Of this 103 only 12 did not have records in the Health Department office for some prior service and two (2) of the 12 were known to the Public Health Nurse serving the area. No findings of significance were found although some required some service.

Problems related to the administration of the Migrant Program have been numerous:

> The task of finding a physician to work evenings for $25. or $30. per session proved impossible, particularly without laboratory, x-ray or pharmacy services. A physician was employed part-time to assist our staff clinician at the time treatment was instituted in addition to our more conventional clinic services. We subsequently learned that no part of her salary could be paid from project funds due to the fact that she saw patients other than migrants and only during our usual clinic hours. An effort to institute a fee-for-service agreement with private physicians failed because again we could assure no payment for laboratory work, x-rays or drugs. An attempt was made to reach an agreement with the county hospital to accept migrants for care on an out-patient basis. This idea was rejected on the basis that the $1,200. allotment was completely inadequate for the task and the inevitable problem associated with having to refuse in-patient care if out-patient care was being given was quickly foreseen.
>
> The second administrative problem arises from the fact that there seems no feasible way to collect data in the detail requested on Page 2 of the reporting kit during general clinics. These clinics are held in nine (9) different offices of the Health Department and serve residents, non-residents and tourists as well as migrants during each session. Since migrants are dispersed over a 900 square mile area (roughly one-half of the county area) and are disseminated throughout the general population (less than 2,000 were in camps,

most of whom are covered by workmans compensation) clinics organized for this selected group are neither feasible nor acceptable to the community.

In summary, it would seem that while traditional services rendered before our participation in the project have been increased; treatment for many illnesses have been instituted; clinic schedules have been relaxed to the point that nursing and/or medical (depending on whether a physician is in the building) services are given on request; that considerable progress has been made in educating the migrants as to how and where to obtain services, and that all concerned have been made more conscious of this group's problems; we have still failed to fulfill two (2) primary requisites; namely, that of organizing segregated clinics during evening hours and of keeping qualitative as well as quantitative records.

POLK COUNTY HEALTH DEPARTMENT
Revised January 1, 1966
Clinic Schedule

LOCATION	TYPE OF CLINIC	DAY	HOUR
Auburndale	X-ray & Health Card	Wed. (2nd & 4th full week)	9:00 - 11:30
	Immunization	Wed.	1:00 - 4:00
	General & Nurse Conference	Thur.	8:30 - 11:30
Bartow	X-ray & Health Card	Mon (2nd & 4th full week)	9:00 - 11:30
	Immunization	Tues.	1:00 - 3:00
	Gen. Med.	Wed. (1,2,3,4th)	1:00 - 3:00
	Maternity Nurse Conference	Thur.	9:00 - 11:00
	Maternity Med.	Thur.	2:30 - 3:30
Frostproof	Imm. & Nurse Conf	Tues.	1:30 - 4:00
	X-ray & Health Card	Wed. (2nd full wk)	1:30 - 3:30
	General Med.	Mon (2nd & 4th)	9:30 - 11:30
Haines City	Gen. Clinic	Tues.	8:00 - 10:00
	X-ray & Health Card	Thur. (2nd & 4th)	1:00 - 3:30
	New Maternity	Wed. (1,3,5th)	8:00 - 11:30
	Maternity (Dr. Brown)	Wed. (2nd & 4th)	8:00 - 10:00
	Immunization	Wed.	1:00 - 4:00
	Well Baby	Fri.	9:00 - 1:00
Lake Wales	X-ray & Health Card	Tues (2nd & 4th full week)	9:00 - 11:30
	General Med.	Wed. (2nd & 4th)	9:00 - 11:30
	Nurse Conf.	Wed. (1st & 3rd)	9:00 - 11:30
	Imm. & Nurse Conf.	Wed.	1:00 - 4:00
	Maternity (Dr. Hardman)	Thurs. (2nd & 4th)	1:00 - 3:00

LOCATION	TYPE OF CLINIC	DAY	HOUR
Lakeland	E.K.G.'s - By Appt.		
	14 x 17 X-rays	Mon.	8:00 - 9:30
	X-Ray & Health Card	Mon.	1:30 - 4:00
	Maternity-Nurse Conference	Tues.	8:30 - 11:00
	General Med. & Well Child	Tues.	1:00 - 4:00
	Maternity Med.	Wed.	8:30 - 11:00
	Immunization	Thurs.	10:00 - 12:00
	Immunization	Thurs.	1:00 - 4:00
	Cardiac by Appt.	Fri. (1st & 3rd)	1:00 - 2:00
	General Clinic	Fri.	10:00 - 12:00
	Chest Clinic	Fri.	9:00 - 11:30
Mulberry	X-ray & Health Card	Wed. (4th)	1:00 - 3:30
	Immunization & Nurse Conference	Tues.	1:00 - 4:00
	General Med.	Fri. (2nd & 4th)	1:30 - 3:00
Winter Haven	Well Baby & Post Partum	Mon.	12:30 - 2:30
	Orthopedic (Dr. Jahn) Jan.,March,May,July, Sept., and Nov.	Tues. (2nd)	8:30
	Immunization	Wed	12:30 - 4:00
	Maternity (Dr. Keith)	Thurs.	8:00 - 10:00
	General Med.	Thurs.	12:30 - 2:30
	Tbc. (Dr. Armstrong) Mar.,June,Sept.,Dec.	Fri.	1:30
	X-ray & Health Card	Tues.	1:30 - 4:00
Waverly	Immunization	Mon. (1st & 3rd)	2:00 - 4:00
	General Med.	Mon. (2nd & 4th)	1:00 - 3:00

MIGRANT PROJECT REPORT DATA - ENVIRONMENTAL HEALTH

NOTE: This form is based on the Public Health Service Reporting Kit Data Sheet 4 "Sanitation Services Related to Migrant Housing and Work Locations."

1. Staff (number - full-time or part-time) 1 Full, 5 Part

2. Location of Camps (attach map showing locations)

3. Laws on Regulations (list type (County-City-State) or attach)

4. Number of Camps in area by size and type () or housing outside of camps ()
   13-Bachelor Qtrs.(Barracks)
   1-Trailer
   3-Apartment type

Total Number of Camps 17 No. Permitted 13

Total Camp Occupancy 2200

U. S. Negro 1645

Puerto Rican 50

Mexican 30

U. S. White 400

B. W. I. 75

Other

5. Total Number of Visits 206

Total Number of Visits by Type:

Complete Inspection 60

Conferences 31

Water Samples 47

Complaints 31

Dog Bites 2

Epidemiology Investigation 3

Sewage Disposal 30

Accidents/Poisonings, etc. 2

SANITATION SERVICES RELATED TO CAMPS (XX) OR HOUSING ( )

Project Period: From: 1 May 65 TO: 30 April 66

(5-7)

ITEM	Adequate		Sub-Stand.		Satis.		Improved
	Start	End	Start	End	Start	End	
TOTAL CAMP EVALUATION							
1. Camp Site	8	8	2	2	10	10	
2. Shelter							
Space	8		5		4	17	13
Ventilation	1		2	2	14	15	1
Lighting			5	1	12	16	4
Heating	4		5	2	8	15	7
Structure	4	2	3	2	10	11	3
Maintenance		2	6		5	9	6
Custodial Care	3	1	6	1	8	15	7
Bedding	4		5	2	8	15	7
Screening	5		3	2	9	15	6
Wiring	4	2	2	1	11	14	5
Fire Protection	3		5	4	9	13	4
3. Food Service							
Dishwashing	7	4	4		6	13	7
Refrigeration	2	1	5	3	10	13	3
Cooking Unit	1				16	17	
Hot & Cold Water			3	2	14	15	2
Storage	2		2		13	17	4
4. Water Supply							
Source	2				15	17	2
Distribution	4				13	17	4
5. Sanitary Facilities							
Toilets	3		2		12	17	5
Showers	5	2	1		11	15	4
Urinals	1		4	2	12	15	3
Laundry	2		3	3	12	14	2
Hot Water	4		2	2	11	15	4
6. Sewage Disposal							
Plumbing	3		4	2	10	15	3
Privies							
Septic Tanks	5		3		6	13	7
Central System	1				3	4	1
7. Solid Waste Disposal							
Storage	3	2	7		7	15	8
Collection	4	2	5	1	8	14	6
Disposal	4	3	4		9	14	5
8. General							
Vector Control	4	1	7	3	6	13	7
Animal Control							
Camp Supervision	5	4	3		9	13	4

8. Chief methods used in obtaining corrections in migrant housing were conferences held with occupanta, camp managers and owners explaining the defects and public health reasons for need of corrections.

   Reasons for failure to obtain corrections of defects:
   1. In many cases the individuals occupying the houses were not interested in making improvements due to an apathetic attitude caused by lack of education and mode of living.
   2. The owners give reasons such as insufficient income from rent, occupants behind in paying rent and the occupants destroy property as fast as improvements are made.

9. Visits to field crop locations where migrants are employed:

   Total number of field locations: 16
   Total number of visits: 22

10.

ITEM	ADEQUATE	SUB-STANDARD	IMPROVED	SATIS.
1. Source of Water		16	12	12
2. Handwashing facilities		16	12	12
3. Excreta disposal		16	14	14

11. Ways in which waste disposal problems were overcome:

   Conferring with field crew chiefs. Explaining public health reasons.

   In view of the fact that the citrus industry differs from vegetable crop farming, the responsible persons could not see why sanitary disposal facilities should be needed for depositing excreta when there was so much space among the trees which shielded the users.

12. The State Sanitary Code and Chapter 386, Sanitary Nuisance Law, were used to evaluate field sanitation.

13. Examples of purposes and methods of educational efforts:

   Conference with groups of owners and managers giving public health reasons for sanitary practices and correction of defects. Showed movies. Held meetings with migrants and civic groups to discuss sanitary regulations. Showed movies in schools on hookworm control and gave talks to school children regarding hookworm control. Stool specimens were collected from school children and examined for hookworm.

14. The number of persons given individual counselling is not known.

15. Three (3) sessions were held with church groups regarding general sanitation problems in housing areas. Forty-five (45) persons attended each.

16. Working relationships were established with nurses, church workers, growers and picking crewleaders; also camp managers. Consultations

held regarding epidemiological investigations and for the purpose of obtaining corrections of defects.

17. As far as orientation and in-service training are concerned, we offered services to civic groups and church groups to train personnel to conduct sanitary surveys in housing areas. Taught limited sanitation enforcement.

18. Problems which prevent or hinder the growers in making improvements are:

    The owners of individual housing are the most difficult to convince to make improvements. Their reasons are: Lack of sufficient rent, short time occupancy, occupants leave without paying and destruction of property by occupant. Health education is the only method through which these people can be made to see the advantages in making improvements. The growers usually are lax in maintaining housing during the season and delay maintenance until the close of the season. The migrants usually do not have too much interest in the maintenance of facilities due to short-time occupancy. Improper storage of garbage is one of the biggest sanitation problems. The migrant has little desire to solve this problem. Consultations with individuals helps frequently to correct the defects. However, they do not have a lasting effect.

19. General appraisal of results of sanitation service:

    Migrants: In most cases the migrants are not very interested in sanitation. Health education and more rigid enforcement of public health laws are required.

    Camp Owners: Camp owners cooperate very well regarding their responsibilities for maintaining housing. The net income each year from crops has a bearing on their attitude toward making improvements. Disasters to crops play a large roll in preventing improvements.

    Community: The community accepts the migrants very well except in isolated cases where racial problems exist.

20. General apparisal of adequacy of service:

    The geographic distribution of the population in Polk County makes it difficult to serve all migrants from a central office. More funds for travel are necessary.

    Health education was very limited. Time not available.

21. Suggestions to help future project operation:

    Improvement on current records should be made to assist in gathering information for compiling reports. More health education is needed. Workshop conferences with other employees throughout the state would be beneficial.

FOOD SERVICE

In addition to the routine investigation of the migrant housing and camp areas there were approximately 292 visits made to food establishments serving the migrant population. These visits resulted in improvements in nearly all instances. Many food establishments in the outlying community areas have started reconstruction in order to conform to the requirements set forth in the State Sanitary Code. It appears that the food sanitation programs have increased the quality of foods offered to the migrants.

A substantial number of primary objectives have been met during the past year. Sanitation activities relating to migrants will increase in the coming report period. The worthwhile effects of the program so far are apparent to public officials and - to some extent - to the more enlightened of the migrant population. Experience gained during the past year will enable the sanitation personnel to perform more efficiently and thus to be more effective during the next year.

MIGRANT PROJECT REPORT DATA - ENVIRONMENTAL HEALTH

NOTE: This form is based on the
Public Health Service Reporting Kit
Data Sheet 4 "Sanitation Services
Related to Migrant Housing and Work
Locations."

1. Staff (number - full-time or part-time) 1 full-time; 5 part-time

2. Location of Camps (attach map showing locations)

3. Laws on Regulations (list type (City-County-State) or attach)

4. Number of Camps in area by size and type ( )
or housing outside of camps( ) Individual housing

Total Number of Units 550

Total Camp Occupancy 3330

U. S. Negro 1400

Puerto Rican 150

Mexican 105

U. S. White 675

B. W. I. ____

Other ____

5. Total Number of Visits 1480

Total Number of Visits by Type:

Complete Inspection 617

Conferences 84

Water Samples 123

Complaints 312

Dog Bites 149

Epidimiology Investigation 20

Sewage Disposal 175

Accidents/Poisonings, etc. ____

SANITATION SERVICES RELATED TO CAMPS ( ) OR HOUSING (X)
Project Period: From: 1 May 65 To: 30 April 66

(5-7)

ITEM	ADEQUATE		SUB-STAND.		SATIS.		Imp-vd.
	Start	End	Start	End	Start	End	
TOTAL CAMP EVALUATION							
1. Camp Site							
2. Shelter							
Space	6	48	436	277	108	267	159
Ventilation	22	113	385	212	143	338	203
Lighting	32	120	254	271	164	289	115
Heating	49	71	313	196	178	258	172
Structure	68	105	339	195	149	345	206
Maintenance	51	111	386	236	113	314	201
Custodial Care	39	57	341	246	73	202	134
Bedding		160	326	106	89	444	335
Screening	66	161	405	29	79	357	238
Wiring	4	37	40	3	160	197	37
Fire Protection	14	155	395	175	143	455	232
3. Food Service							
Dishwashing							
Refrigeration							
Cooking Unit							
Hot & Cold Water							
Storage							
4. Water Supply							
Source	168	21	103	10	249	315	294
Distribution	29	49	143	101	380	422	42
5. Sanitary Facilities							
Toilets	36	20	228	71	72	379	189
Showers	46	20	83	33	250	517	96
Urinals							
Laundry	88	14	197	146	89	404	142
Hot Water	81						
6. Sewage Disposal							
Plumbing	63	6	230	181	64	165	106
Privies		7	40	19	31	52	30
Septic Tanks		32	138	16	86	258	122
Central System							
7. Solid Waste Disposal							
Storage	27		294	112	229	370	192
Collection	61	30	192	44	297	506	209
Disposal	81		178	86	291	464	151
8. General							
Vector Control	13		311	218	227	333	93
Animal Control							
Camp Supervision							

PUTNAM AND FLAGLER COUNTY HEALTH DEPARTMENTS

James R. Sayers, M. D., Director

Area of Putnam County:	803 square miles
Resident Population:	33,000
Number of Migrants:	3,000
Area of Flagler County:	483 square miles
Resident Population:	5,300
Number of Migrants:	500
Migrant Project Staff:	1 Public Health Nurse 1 Clerk-Typist (part-time)

INTRODUCTION AND BACKGROUND INFORMATION

PUTNAM AND FLAGLER COUNTIES

This is our first annual progress report covering the period between September 5, 1965 through April 30, 1966. This covers almost entirely the local crop season for the 1965-66. Many of the workers did not leave until the latter part of May as heavy rains slowed down the potato harvest.

All budgeted positions have been filled. There have been a number of services offered and much work has been done. There has been excellent cooperation among the staff. The services have been well accepted and appreciated by the migrants and also crew leaders and growers. There has been excellent cooperation from the hospitals, physicians and druggists.

We hope to be able to report a much greater volume and variety of migrant health services for the 1966-67, season. We feel that with the experience we have gained we will be able to carry out a far better program during that period.

DOMESTIC AGRICULTURAL MIGRANT SITUATION IN PROJECT AREA

Number of Migrants at Peak of Crop Season

Best available estimates place the total migrant population at 3,500 during the peak of the crop season in April of 1966. Growing conditions were favorable during the season.

For a large number of our workers this is their home base. Many of them maintain their residence here, leaving in May and June and returning in October or November. Many own their homes; while others rent rooms, apartments or houses for the period they are here. The majority of these workers; non-residents, come into this area from Texas and southern Florida. On leaving the area they go to a number of states: Texas; Foley, Alabama; Cape Charles, Virginia; Michigan; Pennsylvania; New Jersey and New York.

The majority of our workers are Negro, with some Cubans and Mexicans. The Mexicans do not stay in the area but a very short time, usually from one to three weeks.

FAMILY HEALTH SERVICE CLINICS

The migrants have been seen this season (1965-66) in the health department clinics. The disadvantages of this were that many times transportation to clinics was not available and also in most instances the worker did not want to lose any time from work. Consequently, unless they urgently needed to see a physician, they would not come. Several of our local physicians saw patients referred to them by the Public Health Nurse and they were reimbursed for services from funds available for this purpose.

Tables showing the number of migrant patients receiving services are included at the end of this section. We feel this number will increase appreciably during the coming season for the availability of these services is becoming more widely known.

Due to the lack of funds for in-service hospital care, there were several persons who did not receive needed hospitalization. Several others were referred to a teaching hospital, one to a Veteran's Administration Hospital and one to a Tuberculosis Sanitarium. These persons were transported to these facilities at the expense of the county or crew leader.

The physicians have been very cooperative in carrying out medical referrals. Approximately 60 have been made. Each referral was carried out.

By teaching migrants in the clinics and in their homes, and camps, we have tried to show them how they can live better, and why these things are important; that is, keeping themselves and their children clean, feeding their children balanced diets, having them properly immunized, etc. Films were shown in one of the Negro schools that a number of migrant children attended. These same films will be used in other schools for the 1966-67 season.

By talking with growers and camp managers and letting them know how and why, we are trying to improve living conditions, and thus improve the migrant's health.

Local church groups have become interested in migrants after having studied this type of person in their home mission programs. They have offered to help in any way they can. They are more aware than ever of the problems of the migrants.

As the result of discovering an active case of Tuberculosis, all contacts were skin-tested (22) and six (6) x-rays made on those deemed necessary. Also a mass Venereal Disease survey was done in the field testing 100 workers. We would like to have done this on a larger scale and this is planned for the coming season.

Twenty-eight health records were given to patients. Approximately 15 health records were presented to us when migrants registered for clinics. Many more told us they had been given records but couldn't find them as they had lost them.

We maintain a good working relationship with the employment service. When the farm labor service bureau meeting of the states employing migrant workers was held, the project nurse and a sanitarian attended the meeting. The information gained from this has proven very helpful.

As stated elsewhere, all migrants who received health services appeared very appreciative. There were a number of cases seen in emergency rooms. Those for whom hospital bed care was provided seemed very grateful - never demanding, but most thankful. (These were the ones accepted by hospitals knowing they would not be reimbursed for services rendered.)

We believe that all migrants in the project area who had a real need for service were cared for.

We very much need in-service hospital care for migrants. The hospitals in the project area, during the 1965-66 season, lost approximately $12,216.00.

NURSING SERVICES IN CAMPS OR OTHER PLACES WHERE MIGRANTS LIVE IN PROJECT AREA

During the 1965-66 season, eight (8) public health nurses provided services for migrant workers and their families as a part of their generalized program. One nurse is employed full-time on the project and the other seven (7) spend a portion of their time on this program.

Home visits to migrants--------251
Migrant visits to clinics------341

All nurses in our migrant area received instructions in the use of the referral system. A total of 25 referrals were made.

The supervising project nurse and part-time clerk-typist attended a two-day Migrant Health Conference held in West Palm Beach during December, 1965.

TYPES OF CLINICS OPERATED BY THE COUNTY HEALTH DEPARTMENT

Immunization
Pre-Natal
Chest X-Ray
Planned Parenthood
V.D.
General Clinic

Number of Clinic Hours--------Total 200

(See the three tables following this page)

SANITATION SERVICES RELATED TO MIGRANT HOUSING AND WORK LOCATIONS

There are no sanitarians employed by the Migrant Project. The four (4) sanitarians on the staff work part-time on this project in connection with their other numerous duties and are doing a commendable job.

Laws for evaluating these camps are found in the:

(A) Sanitary Code of Florida, Chapter 170C-32 "Camps"
(B) Inspection Form, Camps SAN 435 (Rev/8/60)
(C) Inspection Form, Food Service Establishment
SAN 413 (Rev/7/63)

There are 16 camps in the project area. There are 13 family-type camps and three (3) for single males. The combined capacity of these camps is approximately 550 persons.

The following are sanitation services related to camps:

Inspection for permits - 16 visits.

Informal inspection to survey for proper construction, food service,

TABLE I

PUBLIC HEALTH NURSING SERVICES FOR MIGRANTS
1965-66

SERVICE	CLINIC & HOME VISITS																	
	TOTAL		Sept. 1965		Oct. 1965		Nov. 1965		Dec. 1965		Jan. 1966		Feb. 1966		Mar. 1966		Apr. 1966	
	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H	C	H
Immunizations	58	21	2	4	11	0	3	5	9	1	4	1	14	3	10	4	5	3
Prenatal	85	3	7	0	5	0	7	0	18	1	9	0	11	1	20	1	8	0
Post Partum	14	68	0	0	1	7	3	3	3	3	1	12	1	11	4	11	1	21
Child Spacing	30	14	0	0	1	1	5	1	2	2	6	0	3	0	8	7	5	3
Chest X-Ray	6	0	0	0	0	0	0	0	1	0	0	0	0	0	5	0	0	0
Tuberculosis	10	3	1	0	4	2	1	0	0	0	0	0	3	1	1	0	0	0
Venereal Disease	14	0	0	0	0	0	0	0	2	0	0	0	0	0	7	0	5	0
Intest. Parasite	19	1	0	0	0	0	2	0	3	0	7	0	0	0	5	1	2	0
Diabetes	7	7	2	0	0	0	1	0	2	6	1	0	0	0	0	0	1	1
Injury	3	1	0	0	0	0	2	0	1	0	0	0	0	0	0	0	0	1
Dental	2	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0
Morbidity	38	82	0	0	1	1	0	1	9	14	7	4	1	11	11	21	9	30
Health Appraisal	55	51	0	1	4	7	2	5	5	5	1	3	5	2	25	13	13	15
GRAND TOTAL	341	251	FIELD VISITS: 165 (Tests for V.D. and TB and other Health Appraisals)															

TABLE II PREVENTIVE

SERVICE	SEX AND AGE GROUPS									
	TOTAL		0-15		16-49		50+		Unkn.	
	M	F	M	F	M	F	M	F	M	F
DPT	17	20	17	17						3
DT		7				7				
POLIO	13	23	13	17		6				
SMALLPOX	2	3	2	3						
CANCER CYTOLOGY										
CHEST X-RAY	3	2			3	1		1		
CHILD SPACING		21				17				4
HEALTH APPRAISAL	35	11	18	26	10	20	12	1		2
NUTRITION										
POST PARTUM		14					13			1
PRENATAL		27		1			25			1

TABLE III CURATIVE

CONDITION OR PROBLEM	SEX AND AGE GROUPS									
	TOTAL		0-15		16-49		50+		Unkn.	
	M	F	M	F	M	F	M	F	M	F
DIABETES	1	2				1	1			1
INTEST. PARASITE	10	10	10	9						1
RHEUMATIC FEVER										
TUBERCULOSIS	3	2			2	2	1			
VENEREAL DISEASE	4	1	1	1	1		2			
POISONING										
DENTAL		2				2				
INJURY	4				1		2		1	
CARDIAC	1						1			
EYE										
SKIN	2	1	1		1	1				
CRIPPLED CHILDREN										
OTHER	26	16	6	3	7	7	4	1	9	5

water supply, sanitary facilities, sewage disposal, garbage and trash disposal, pest control and general cleanliness - 55 visits.

There were six (6) camps meeting existing standards at the beginning of the season. Two (2) camps were brought up to standard requirements during the 1965-66 season. Seven (7) camps met standards at the end of the season.

DEFECTS FOUND IN CAMPS

TYPE OF DEFECT	NUMBER FOUND	NUMBER CORRECTED
Broken Screens	7	7
Pets in Kitchen	1	1
Smoking in Kitchen	1	1
Inadequate Fire Protection	2	2
Toxic Materials in Kitchen	2	2
Inoperative Toilet	1	1
No Garbage Can Lids	8	6
Health Cards Expired	3	3
Paint and Cleaning	7	5
Inadequate Sewage Disposal	6	5
TOTAL	38	33

Methods used to obtain corrections of defects is "moral persuasion" which consists of explaining reasons for the regulations and the results of unsanitary conditions that may develop from failure to comply or correct defects. Showed a group of growers from one area some approved facilities in another area. One sanitarian assisted in arranging for a Farmers Home Administration Loan and helped draw up camp plans that would be approved by the health department.

Failure to obtain corrections is often due to inability to overcome a lethargic attitude on the owner's part and also the expense involved.

There is no comparative data from previous years.

A large number of migrant families live in the municipalities and surrounding areas. A few homes are in good condition, some are in fair condition; but most are poor to barely habitable. Approximately 250 to 300 homes are in this category. There are a number of migrant workers who are single men that submerge themselves into the local population, renting rooms in private homes or a cheap boarding house. Some stay with relatives or a local girl-friend. There are probably 350 to 400 in this latter category.

There were seven (7) visits made to other than camp locations in efforts to upgrade the facilities and improve the general sanitary conditions.

There were two (2) locations visited. Eleven (11) housing units were visited at these locations. Six (6) housing units were brought up to standard during the project period, with the same number meeting standard at the end of the season.

There were six (6) defects found; screening, ventilation, garbage and trash disposal, drainage, fire protection and heating. All of these were corrected except heating.

Owners were advised as to defects and practical reasons for correction of same. All owners have been cooperative and willing to make corrections subject to economic ability. One defect, heating, has been put off due to hot weather.

There is no comparative data available from previous years.

Nine (9) field locations were visited, as compared with an estimated 60 field locations where migrants are employed.

There were 33 field visits made throughout the season concerned with field sanitation.

The sanitarians have talked with camp managers regarding the necessity of better facilities and proper care for these people, particularly in regard to crowded conditions, contagious diseases and general insanitary conditions. Migrants have a tendency to be apathetic and lazy which, combined with their general lack of education, requires a great deal of direction, guidance, counselling and actual practical training in developing sanitary personal habits. The camp managers and crew leaders are the only people who can do this effectively.

A few random individuals may be influenced by the doctor, nurse or sanitarian but the great majority are never seen by health department personnel. This situation is gradually changing.

There were three (3) camp managers and their wives and approximately 20 other individuals given counselling on specific problems; namely building completely new facilities, adding on toilet facilities - including showers and baths, inadequate drainfield, and failure of camp managers to report breakdowns in sewage systems to proper people.

The following are working relationships:

NURSE - The entire program is dependent on and revolves around the nurse. The nurse meets a considerable number of these people individually and each of these contacts may be most valuable to the individual. The nurse knows and has considerable influence with the camp managers and their wives, who are the key people in developing this program in the camps. The nurse is beginning to know the crew leaders, who will be most valuable in reaching the individuals not in camps. She is able to observe and report to the sanitarian conditions which need to be corrected and which otherwise would possibly not be found.

The grower-nurse-sanitarian relationship is developing slowly and will eventually be the backbone of the program, in which the full-time nurse will be an absolute necessity.

GROWERS - These people are slow to change and reluctant to do anything their fathers and grandfathers did not do. They are, however, normally intelligent and can be made to see that changes and improvements in environmental health relationships need to accompany the progress in other farm practices.

CREW LEADERS - These people are difficult to find and some are difficult to talk to. They will provide an important link in the program as they are drawn in.

EMPLOYMENT SERVICE - These people have a well-developed inter-state organization that could quite profitably adapt itself to this program.

As yet we have not made any provision for orientation or in-service training.

Principal deterrent to housing and sanitation improvements is cost. Some growers lose money several years in a row, then a good year pays most of the back debts. There is also a feeling that such improvements are wasted on an ignorant, backward, inconsiderate and unappreciative labor force. This contention has been largely well-founded, and only now are attempts being made to improve the attitude of laborers, as well as their education in proper use of facilities. This is a long-time process and involves all the rest of the program and the efforts of all the people directing and cooperating in it. All other problems are trivial compared to this.

Community understanding is quite limited, mostly it is an attitude of putting up with a necessary evil, developed from some unfortunate experiences in the past.

Grower-migrant relationships are quite varied. Some growers deal wholly with crew leaders and have no relationship at all with the migrants. Others, usually the smaller grower, deal individually and quite often develop ties which endure through the years, as individuals or small groups return to work for the same man.

It is possible to keep fairly close surveillance over the camps and about three (3) central housing locations but as mentioned before, a great many of the migrants live individually with the local population and are practically impossible to find.

Needs for health education are being met gradually. This is a long-time need and because of ingrown habits, including a natural reluctance to change and an inborn distrust of white officialdom, these people are not only difficult to influence, but very hard to locate. As the nurse becomes familiar with the territory and known to the people, she should have a profound influence in this regard. This influence is noticeable already among the wives of the leaders and some of the migrant women.

HEALTH EDUCATION SERVICES

This subject is embodied in other segments of the project report, such as Family Health Service Clinics and throughout the segment headed Sanitation Services Related to Migrant Housing and Work Locations.

OTHER ITEMS PERTINENT TO FUTURE PROJECT DEVELOPMENT

There is a tendency among the migrants to help each other. If one is sick, there is usually someone around to see that this person is cared for. On visits to the camps and in the field, they are anxious to tell the nurse if their friend is sick.

We have found that most of the crew leaders and their wives have been quite cooperative. If one of their crew is sick and needs medical attention, they let us know immediately. They provide transportation to the clinic or doctor's office. In one instance, the crew leader paid the ambulance fee to a neighboring city. We feel, as we continue to work with these people, that they will strive to do more for themselves. We have noticed their appearance and conversation have improved, when they have found someone is interested in them.

We feel much has been done in providing health services for migrants. Heretofore their needs have been neglected due to lack of money and not knowing where to turn for help.

During the 1966-67 season we would like to increase the number of migrants coming to our clinic, conduct a mass-chest x-ray and venereal disease survey, as well as a diabetic screening. We would also like to participate in dental screening of all migrant children and to use films and other methods in cooperation with the schools, to teach these children a better way of living.

SARASOTA COUNTY HEALTH DEPARTMENT

David L. Crane, M. D., Director

Area of County: 586 square miles

Resident Population: 95,000

Number of Migrants: 4,500

Migrant Project Staff: 1 Public Health Nurse
1 Sanitarian
1 Clerk-Typist (part-time)

SARASOTA COUNTY HEALTH DEPARTMENT

MIGRANT PROJECT ANNUAL PROGRESS REPORT

May 1, 1965 - April 30, 1966

I. INTRODUCTION

While Sarasota County made an extremely slow start toward the provision of a reasonably adequate health service program for Migrant Agricultural Workers and their families, it may now be categorically stated that a sound program is under implementation and that we look forward with real anticipation to the provision of steadily improved and more comprehensive programs in the next growing season.

By way of inventory, we started the year currently being reported with an idea and adequate funds. Six months (May - October) evaporated before a personnel assignment was made. Finally, in November, 1965, a capable nurse who had just received her M.P.H. in Public Health Nursing was nominated for the vacant position and a part-time clerk was appointed to provide the necessary staff support. A sanitarian was asked to provide part-time service until a good, permanent sanitarian could be located. This required an additional four months during which one full-time professional was available with spotty service from Sanitation on about a one-third time basis, plus half-time support from the staff. Finally by March 1, 1966 - ten months after initial project participation - a full staff was fielded. Obviously strike-outs, fouls and errors characterized the first innings and by the time the full team took to the field, "things looked bad in Midville." Morale was low and there was some evidence of pessimism among the staff involved. A revitalized effort was put into effect immediately and while the course has not been smooth all the way, very real progress has been made; we are told by outsiders, even by migrants, that more has been done since the new year than in the previous ten years.

The report which follows indicates what has been done, in greater or lesser detail, in the past twelve months - keeping in mind the game for this period was half over before we started. The groundwork has been laid for a successful program next season.

The initial effort was entirely educational in nature. The Public Health Nurse became acquainted with our migrants, determined their major problems and needs and started educational activities - general hygiene, infant care, social adjustment, expectant mothers' classes and the like. As Sanitation became involved, education broadened to include better housing, proper waste disposal, environmental cleanliness, insect and rodent control. Then concentrated work started with a full staff to include work with growers, community agencies, federal programs (VISTA, OEO). Local and State programs were involved in "clean-up" campaigns, destruction of substandard and dangerous housing.

Concommitantly, efforts were begun to get physicians, dentists and hospitals to cooperate. Maternity and contraceptive clinics were opened to migrant women. Immunizations were provided migrant youngsters and a Day Care Center was opened. Physicians and dentists agreed to treat migrants in their offices and many did so free-of-charge. The hospital emergency room agreed to provide service at a fee below that approved for the State as a whole. A beginning transportation network was set up using VISTA, Nursing and Red Cross autos to get migrant patients to the medical care facilities which are all centrally located.

These activities will grow and by next season we plan on at least one family medical clinic each month, hopefully more, in the migrant area and in the evening, if possible. All other services are to be expanded as rapidly as feasible in order to provide a service of which we can all be proud in Sarasota County.

Following the summary of accomplishments toward our objectives and the narrative report, our continuation request is appended for consideration. We now have the team, the experience and the desire to do the job that needs doing. Support for the next project year will need to be based, to a great extent, on faith that we can produce since, in all honesty, we have so little proof in these meager pages to indicate the extent of past performance. As members of the team we pledge ourselves to provide that proof, in action, to the jury which really counts - the migrant and his family.

II. ACCOMPLISHMENTS TOWARD SPECIFIC PROJECT OBJECTIVES

1. To improve environmental aspects of migrant's existance.

   a. Through stricter enforcement of Camp Regulations.

   Two of our four migrant camps were permitted this year. The worst camp for migrant labor housing will be eliminated during the summer, many substandard houses have already been destroyed (see narrative). The other three camps have been notified they must meet the Code or be "padlocked" next season. Two meetings have been held with the "big three" growers in this county plus representatives of the Farmers Home Administration to discuss construction of a central labor pool facility. Hopes for fruition were somewhat dimmed by the growers' attitude, but we expect to keep the heat on in hopes of eventual agreement to such a plan.

   b. Encourage growers to provide field sanitation facilities.

   Main emphasis has been on the permanent housing, to date. Now that this is improving field toilets, possibly the chemical type, will be our next target.

2. To develop, utilize and revise when advisable a uniform set of forms and records for project counties. The County Director was appointed to this committee and a good first meeting was held from which, we hope, a uniform record system will evolve.

3. To test liaison workers to extend health education and obtaining information on migrants. In a sense this has been accomplished through VISTA. They have acted as educators in many fields, including health, and living amongst the migrants they have acted as key information gatherers. Properly motivated and trained liaison workers from the migrant ranks could probably do a better job but good VISTA personnel have already done the field work and proved this can be an effective tool. The greatest caution is rigid screening and careful selection

IMMUNIZATIONS

TYPE OF VACCINE	AGE GROUP			TOTAL
	Under 1-Year	1-4 Years	5 and Over	
Polio	3	7	62	72
Smallpox	1	5	14	20
DPT	2	19	32	53
DT			34	34
Measles		14	9	23
			TOTAL	202

PERSONS REFERRED TO
OTHER SOURCES OF SERVICE

Florida Crippled Childrens	1
Ophthalmology	1
Dental	2
Planned Parenthood	20

NAME	AGE	DATE TINE 1966	DATE RESULTS	DATE X-RAY 1966	DATE RESULTS	FORWARDING ADDRESS	REMARKS

(*) NOTE: FORM USED IN MASS TB TESTING IN MIGRANT CAMPS (FORM I) of personnel. This is the weakest point in the VISTA effort.

4. To inform the public and special groups on the migrant's problems. Nearly as much time and effort has been and must be spent in educating the public about the migrant, who has largely been considered a necessary evil, as in educating the migrant himself. VISTA, The Migrant Ministry, O.E.O. and other programs have helped considerably and public attitudes are changing.

5. Encourage use of Migrant Referral System within and without the State. This county has agreed to participate in continuing tests of the referral system and we are attempting to make maximum use of the system.

6. To offer more comprehensive medical and dental treatment to migrants. While Sarasota County was not included in the counties to attempt this, we felt this was a major need and, therefore, began our own campaign to provide service. Migrant women are now eligible to attend maternity and contraceptive clinics, the children attend dental and immunization clinics. We propose a family health clinic in the migrant area next season. Other health department clinics (V.D., T.B., etc.) are open to, and utilized by migrants.

7. To help solve the migrant's transportation problems in obtaining medical care. To date we have depended upon volunteer transporters (nurses, VISTA personnel, neighbors, etc.), however, this has not proven entirely satisfactory so that a new effort is being made to provide subsidized transportation at 10¢ per mile using VISTA, Red Cross and other automobiles for this service. This method will be concurrently evaluated for applicability in this program.

The Narrative which follows, plus the tables and photographs, points up some of the high spots in this program, primarily during the past four months (January through April).

FAMILY HEALTH SERVICE CLINIC

SERVICES PROVIDED, ACTIVITIES CARRIED OUT, AND PROCEDURES FOLLOWED TO MEET EACH OBJECTIVE:

Since no central clinic has yet been established in Sarasota County, our Family Health Services are provided by several different sources. Certain clinics at the hospital and health department are open to Migrants and their families. In addition, practicing physicians and dentists will accept referrals for medical care. The Hospital Emergency Room accepts Migrants who are acutely ill or injured for such care as is needed and can be provided through this facility.

We started a mass tuberculin Tine test program in Sarasota County in March, 1966. Our objective was to test as many migrant workers as possible, for tuberculosis, before they departed from the Sarasota community. Tine test clinics were held at labor camps and on field site locations in order to cover as many migrant workers as possible. In cooperation with this department, on April 6, 1966, the mobile x-ray unit spent three hours in the migrant camp area. One-hundred and sixty-six (166) persons were x-rayed.

TINE TESTS

NO. TESTED	NO. READ	POS.	NEGATIVE	AGE 14-44	AGE 44-Over	AGE Unknown
136	104	46	58	111	20	5

ALL POSITIVE TB'S HAVE BEEN X-RAYED EXCEPT SEVEN (7), THESE SEVEN WERE REFERRED TO OHIO.

Immunization clinics are held in the child care center at Johnson's camp. These are carried on in the evening and have been correlated with our Health Education Program. The remainder of our migrant children are immunized for D.P.T., Polio and Smallpox by a Public Health Nurse in the Fruitville school where our migrant children attend.

(*) NOTE: For pictures and charts on immunization clinics see following pages.

Our Maternity clinic is located in Sarasota Memorial Hospital. The Venereal Disease clinic is located in the Health Department. Other medical problems are referred to private physicians participating in the migrant project. Other cases are treated at the emergency room of the hospital. Dental treatment for children of school age is provided by a dental preceptee. We have seven (7) dentists who have agreed to participate in the project, treating adults on an emergency basis and children needing surgery or extensive dental care.

NURSING SERVICES WHICH WERE PROVIDED IN MIGRANT CAMPS AND OTHER PLACES IN PROJECT AREA.

Number of full-time nurses----------------------------1
Number of PHN's working with migrants----------------3

For number and location of camps and other concentrations of migrant housing within the project area, see Sanitation Services Related to Migrant Housing and Work Locations.

The number of camps and other concentration points visited on a regular schedule per week by 1 PHN--------------4

The total number of persons visited during the project period, November 1, 1965 through April 30, 1966----478

Estimated percentage that were migrant--------------90%

Number of conditions found requiring care by type of condition and persons referred to family clinics (field clinics):

Communicable Diseases		67
Tuberculosis	55	
Venereal Diseases	5	
Other communicable diseases	7	
Chronic Diseases		28
Cardiovascular	2	
Other Chronic Diseases	24	
Cervical Cytology	2	
Maternity		12
Child Health		93
Less than 1 year	32	
1 - 4 years	20	
5 years and over	43	
Mental Health		13

For examples of purposes and methods of educational efforts and number of persons given individual and group counselling, see Health Education Services.

PROBLEMS WHICH HINDERED EFFECTIVENESS OF SERVICE:

(1) Transportation is a major problem. Patients must travel many miles to reach special clinics, physicians and a hospital. This problem has not been solved. Crew leaders and/or other migrant workers will aid in transportation. Vista workers do assist in transportation when no other means are available.

(2) Other problems encountered are the migrants' lack of knowledge regarding the medical services available to them and their reluctance to seek medical assistance because of finance, embarrass-

ment and humiliation. There is yet some superstition and ignorance. Many workers have never been in contact with a licenses Medical Doctor.

HOW ARE THESE PROBLEMS OVERCOME?

(1) These problems are being overcome gradually. Project (M) Nurse informs Vistas, crew leaders, growers, store managers, migrant-aide and farm workers about the services that are available to migrant workers.

(2) Migrant workers are referred to physicians who have willingly agreed to accept them as their patients. When the patients are referred to a physician or to the hospital, they are provided with a written form which identifies them and qualifies them for medical service.

(3) Absence of Family Clinic. Because of this county's unique structure in medical practices and remoteness of the migrant camp areas, efforts to provide a convenient clinic service have not been successful as yet though continuing community education and broader understanding of the migrant's needs portend well for such a development in the future.

For other problems which were overcome refer to Health Education.

FACTORS WHICH CONTRIBUTED TO EFFECTIVENESS:

(1) Cooperation from local physicians, dentists and hospital. Changing attitude of the general public and community groups interested in welfare service.

(2) Introducing the referral form which the patient presents to the physician and hospital when seeking medical service.

(3) "Project M" Nurse holds numerous Health Education programs resulting in improved health attitudes of individuals and groups. Vista workers, being our liaison in various community projects; have helped, e.g., IMMUNIZATION CLINIC - Vistas contacted families and stressed again the importance of immunization.

(5) Health Department staff, church groups and individuals have participated in informational sessions, dealing primarily with the needs for better personal hygiene, overall sanitation, etc. These educational sessions are continually leading to better understanding and relationship with the migrant worker.

GENERAL APPRAISAL OF RESULTS OF NURSING SERVICE - EVIDENCE REGARDING:

(1) Migrant families have indicated appreciation for the services rendered in the past few months. One child stated "Now I enjoy living at Johnson's camp."

General appraisal of results of nursing service and evidence regarding: (Please see Health Education)

SANITATION

Migrant labor camps are inspected and permitted in accordance with Chapter 170C-32 of the Florida State Sanitary Code. Buildings, electrical work, plumbing installations or repairs must also comply with the Sarasota County Building and Zoning Code.

The majority of defects noted on camp inspections can usually be corrected after frequent visits; provided the proper individual was contacted at the time of inspection, such as the resident supervisor, crew leader, or in some cases, the owners. The proper method to correct these deficiencies must be explained to the individual, which is basically an educational process.

Defects such as inadequate housing, water supply problems, structural defects, etc., and possibility of condemnation are brought to the owners' attention. Most of the camps are small and require programming of work over a long period of time.

Many defects seemingly are not corrected because they recur at such a rapid rate. Failure to obtain corrections stems largely from a lack of spare time by many of the camp operators or farmers and, in some instances, from apathy on the part of farmers, operators, or crew leaders who are disinterested or unappreciative of camp conditions as these relate to the migrant laborers. Farmers and camp operators begrudge spending more money than they must.

Discussion of the entire camp problem by the sanitarian with the camp operator is essential. Cooperative attitudes can easily be destroyed if past mistakes have not been noted or important details were overlooked and must now be corrected.

Conscious and determined respect for a single standard and uniformity must be observed. Let one farmer get the impression that he is being required to institute a proceeding which appears to apply only to him and trouble is being stored up for the future.

TYPICAL PROBLEMS INVOLVED AND ATTEMPTED SOLUTIONS THROUGH COUNSELLING IN: "SANITATION"

BUILDINGS: Discussions with camp owners, crew leaders and migrants to show the importance of maintaining existing facilities.

Sanitarian must point out the wisdom of continual maintenance in order to prevent extensive future repairs. The migrant workers must also be continually informed and educated in the advantages of maintaining better sanitary conditions in their quarters.

GARBAGE AND TRASH DISPOSAL: This is a continuing problem at most camps.

Even though cans are provided for garbage and trash, regular collection and proper disposition in many cases is nil. Efforts for regular pick-up for garbage and trash is under investigation and is the obvious answer. In many cases this is a problem due to the remoteness of the camp.

PLUMBING: A serious problem in migrant camps due to the misuse of plumbing fixtures.

Here the main solution lies in the education of the migrant worker. Many times owners are reluctant to install new fixtures, feeling that they will just be destroyed again. Close inspection by a sanitarian can and does help this situation.

WATER SUPPLY: All private water supplies are tested for bacteriological quality.

Periodical checks are made of all private water supplies and if returned "Unsatisfactory" chlorination instructions are given and repeated samples are taken until a "Satisfactory" report is returned.

SEWAGE DISPOSAL: Pit privies are inadequate and insanitary. Where toilets are provided, maintenance problems arise.

Where pit privies exist continual inspection must be made and wherever possible Sani-jons installed in their place. Where toilets are provided, destruction and misuse are the main problem. In most cases education of the migrant worker is the ultimate answer and solution.

One example of this occured during the past season. A group of Mexican laborers were discarding soiled toilet paper on the floor beside the commode. Investigation revealed this to be common practice in the country from which these workers came, as drains were not adequate to accommodate toilet paper. The migrants were informed that our drains and septic tanks could accommodate toilet paper and it was proper to flush same down the toilet. Instructions and education completely solved the problem.

PEST CONTROL: A serious problem due to fly density in any agricultural area.

Advice must be given to both owners and migrant workers regarding care of screens, garbage storage, rodent control and related problems.

"FAMILIARIZATION"

In order to familiarize ourselves with the problems and solutions as described above a survey was made of the migrant camps in the Fruitville area. Information was gathered as shown on forms "A" and "B". This information gives us a clearer picture of the wants and needs of the migrant workers and the problems of the farmers.

Forms "A" and "B" follow on the next two pages.

Precinct________ Location____

Owner______________________________ W__ C__ Mailing Address______________________

Occupant___________________________ W__ C__ Mailing Address______________________

No. of Occupants__________ Type of Building_________ No. of Rooms______

State of Repair____

Water Supply (Type)____

Casing (Type and Depth)____

Surface Protection____

Method of Delivery____

Excreta Disposal (Type and Condition)____________________________________

Condition of Premises____

Evidence of Rodents or Harborage_________________ Livestock____________

Screening_________________________________ Fly Breeding__________

Mosquito Breeding____

Garbage Disposal____________________ Rubbish and Litter____________

Sink Waste____

______________________, Sanitarian

Date______________________________

FLORIDA STATE BOARD OF HEALTH
Sanitary Survey Record
SAN-400
Revised 7/63

FORM "A"

MIGRANT INDEX FILE
Sarasota County

Date____________________

Family Name________________________ Address__________________________

Sex Age School

Father ____
Mother ____
Child 1.____
2.____
3.____
4.____
5.____
6.____

Other members of household Relationship
1.____
2.____

Ethnic Group (Circle) Negro Puerto Rican Mexican Anglo Cuban Other

Employer________________________ Crew Leader__________________
Date arrived from:____________________________________
Date to depart for:___________________________________

FORM "B"

MIGRANT CAMPS IN FRUITVILLE AREA

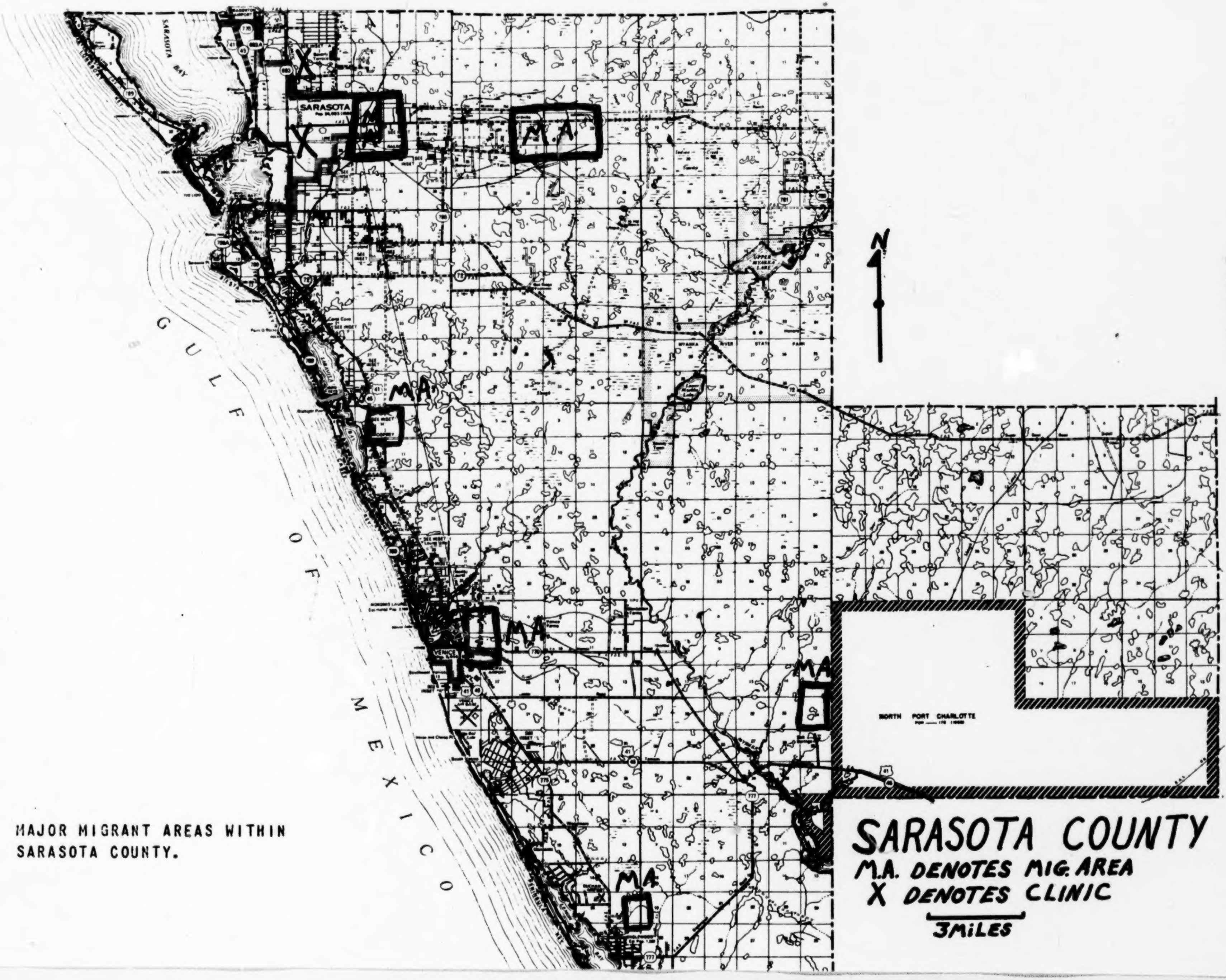
CAMPS	NUMBER OF CAMPS	POPULATION OF CAMPS
Camps at the Start of Project Year	4	393
Camps Permitted During Project Year	2	274
Camps Not Permitted During Project Year	2	119

CHART I

CHART II

CAMPS	FOOD SERVICE	# APPRD. PRIVIES	# UNAPPRD. PRIVIES	SAT. WATER SUPPLIES	CAMPS WITH INDOOR TOILETS	APPRD. SHOWERS PROVIDED	# HOUSING UNITS	
FANCEE FARMS	0	0	1	Yes	No	No	6	
SABABO	0	0 (*)	0	Yes	Yes	Yes	20	
JOHNSON'S CAMP	0	0	52	No	No	No	67	Beginning of Project Year
KEYSER'S CAMP	0	0	6	Yes	No	No	21	
FANCEE FARMS	0	0	1	Yes	No	No	6	
SABABO	0	0 (*)	0	Yes	Yes	Yes	20	End of Project Year
JOHNSON'S CAMP	0	6	20	Yes	No	No	45	
KEYSER'S CAMP	0	6	0	Yes	No	No	21	

(*) Central Toilet

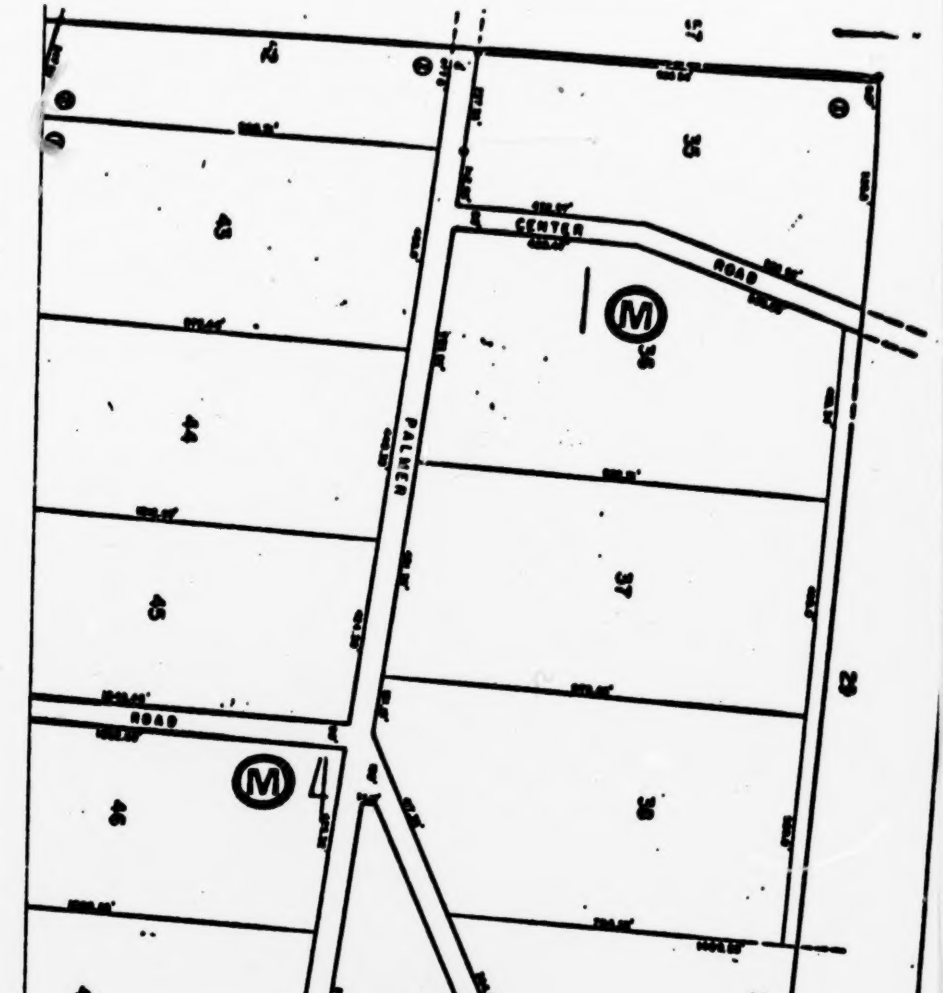

SARASOTA COUNTY
M.A. DENOTES MIG. AREA
X DENOTES CLINIC
3MILES
GULF OF MEXICO
SARASOTA BAY
SARASOTA
VENICE
NORTH PORT CHARLOTTE
N
M.A.
M.A.
M.A.
M.A.
M.A.
M.A.
M.A.
X
X
X
X

MAJOR MIGRANT AREAS WITHIN
SARASOTA COUNTY.

The Migrant Labor Camps, within Sarasota County are located approximatly 9 miles due east of downtown Sarasòta, Fla. They lie in the area known as (Palmer Farms, 5 TH Unit S/D PB3 PI5) Sarasota Co. Fla.

PROJECT M

1 Fancee Farms
2 Johnson's Camp
3 Keyser's Camp
4 Sababe


CENTER ROAD
PALMER BOULEVARD
ROAD
EAST ROAD
ROAD
M
1
2
3
4
35
36
37
38
29
30
31
32
33
40
41
42
43
44
45
46
47
48

MAP DEPICTS FRUITVILLE AREA. MAJOR EFFORTS AND TIME HAVE SO FAR BEEN CONFINED TO THIS AREA.

MIGRANT CAMP LOCATIONS

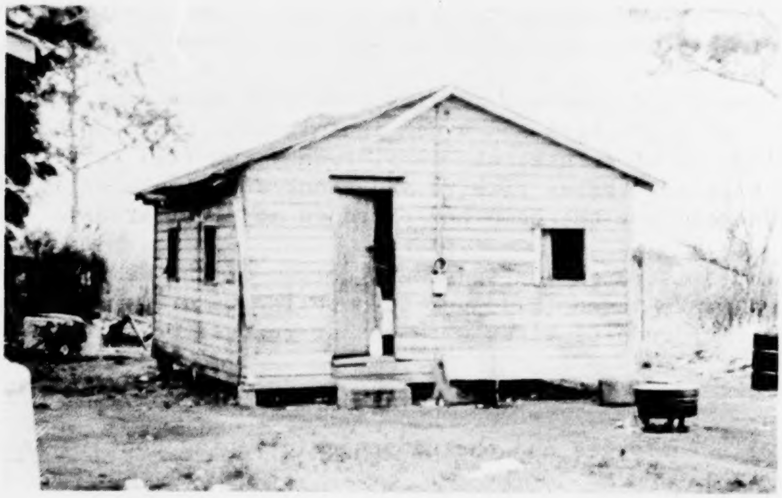
THE FOLLOWING PAGES CONTAIN A WORD PICTORIAL VIEW OF THE MIGRANT CAMPS IN THE FRUITVILLE AREA:

FANCEE

FARMS

Fancee Farms, a migrant labor camps, is located on Center Road in Sarasota County. It is of cement block construction with a metal roof. This camp has barracks-type rooms, houses single male and female, Mexican and Negro workers. Population varies, at times reaches as high as 60 people. The camp is overcrowded during the season and Mr. Pat Ferlice, owner of Fancee Farms, has plans to enlarge the camp in the near future.

Fancee Farms is a permitted camp, its major problems are a need for regular garbage collection and new toilet facilities.



JOHNSON'S CAMP

Johnson's camp is an unpermitted camp located on Palmer Boulevard, Sarasota County. It is the oldert and most primitive migrant camp. Pictured on the preceding page is a typical house, no running water, and in some cases, no electricity. This rat-infested area poses a real threat to the residents and challenge to this department. Vista and other volunteer helpers, work here daily. A Child Care Center has been established and is in operation. Recently an old house was cleaned and painted and is presently being used as a church.

A house-to-house survey with the help of Vista workers revealed the following data:

There are sixty-seven (67) houses in the camp of which thirty-nine (39) are inhabited. There are thirty-two (32) privies, of which only eight (8) are sanitary. There is also one (1) building which is used as a Church, Child Care Center and meeting hall. One-hundred-eight (108) people live in this camp, fifty (50) adults and fifty-eight (58) children.

Water for the camp use came from two sources, one 600 foot well, distributed to outside taps; five (5) shallow wells connected to pitcher pumps. Samples from the taps and pumps were collected and all contained Coliform organisms. The system was Chlorinated and samples taken March 21, 1966 proved to be bacteriologically pure. The pitcher pumps have been removed and capped.

As a result of continual contact by a Sanitarian with both the growers and migrant workers, a much greater understanding of their wants and needs has been realized. This department received written permission to control-burn the entire area of Johnson's camp and to destroy all uninhabited houses and/or any other buildings that were deemed necessary. This department, in coordination with other county agencies, contacted the Fird Department and Forestry Unit. On April 14, 1966, (see clipping) the control-burning of brush, privies, houses, etc., began. Vast areas both east and west of the camp were cleared and burned. This required the use of one bulldozer, one caterpillar tractor, and three pieces of fire equipment. Houses and privies were moved into these cleared areas and burned. As of this date the following has been accomplished:

Twenty-two (22) houses and numerous privies have been destroyed. Approximately five acres of high grass and brush in andaround the camp have been burned. Literally tons of refuse, tin cans, twenty-two (22) refrigerators, numerous washing machines, bales of wire and about anything else imaginable have been removed from the camp and piled in adjacent areas.

The junk yard which existed on the southwest corner of the camp has been eliminated. Twenty-seven (27) junk automobiles were cut in pieces and carried away. Hundreds of tires were either removed or burned.

NOTE: The two following pages and the newspaper clipping contain data on Johnson's Camp.

Keyser's Camp is located on the corner of Palmer Boulevard and Shannon Road. Although Keyser's Camp is of cement block construction with a metal roof, it still remains an unpermitted camp. Destruction by the migrants is high and is a major problem. Reluctance of the owner to rectify deficiencies also hampers this department. In spite of these obstacles some improvements have been made.

The old existing pit privies were demolished, the holes filled in with dirt and replaced with new Sani-jons.

The camp provided showers; however, the drains were plugged up. These have been opened and at present are operating properly.

Garbage cans are furnished and the crew leader provides regular pick-up and disposal of this garbage.

A block survey in Keyser's Camp was completed, with the aid of Vista workers, and revealed a definite over-crowded condition in this camp. There are twenty-one (21) one-room apartments which are presently housing thirty-five (35) adults and thirty-three (33) children.

In spite of these improvements, major problems still exist. Almost all screens are torn, many windows broken and unvented gas stoves are used for heating. These situations must be corrected before this camp can be issued a permit.

SABABO CAMP

Sababo Camp is located on the corner of Palmer Boulevard and Niobe Road in Sarasota County. Sababo is by far the best migrant camp in this area. During the winter season a full-time maintenance man worked in the camp. This appeared to be beneficial to the owners as evidenced by the lack of damage to property occurring during the season. Camp construction is cement block with metal roof. There are twenty (20) one-room family quarters, housing at times over one-hundred (100) occupants. The camp has adequate laundry and toilet facilities and these are well maintained. Garbage and trash are removed by the owners, Sarasota Growers, Inc., and the only real problem is over-crowding, in some cases due to large families.

HEALTH EDUCATION

There has been a continuing program of Health Education by a sanitarian and nurse. Films such as "Safe Foods," "Healthier Place to Live" and others have been presented in conjunction with lectures on general sanitation. At the onset these films and lectures were primarily slanted toward the children from the various Migrant camps. With the aid of Vista workers, both a Boy's and Girl's Club have been formed. Work with these children has been very gratifying, though somewhat slower than had been anticipated. The children had to be calmed down to a point where an educational program could be presented. This has taken many hours of time on the part of both the nurse and sanitarian. In the last few months a distinct change seems to be taking place. The children are becoming more aware of the need for better living conditions as well as the need for more healthful personal hygiene. The most encouraging part of this program is the regularity of attendance and the enthusiasm of the children.

(See photograph top of next page.)

An Adult Health Education program has been started. This was found to be difficult due to the fact that it is almost impossible to get the adult

migrant laborer to attend a formal type meeting. We have found the best approach to solving this problem is by personal contact with the migrants at their homes. The older migrant laborers are aware, of course, so indoctrinated with their environment that these conditions have literally become a way of life. Here, a superstition, lack of education and lack of understanding reaches its highest degree. Many times these migrant workers are improperly treated through advice of neighbors and in some instances, taken advantage of by untrained practitioners. This is a particularly serious problem since the people are acting in good faith and do not realize they are being improperly treated. These problems can only be solved through continuing contact and a slow, gradual process of education and understanding. Some have never seen a qualified physician.

2

217

HEALTH EDUCATION (CONTINUED)

ACTIVITIES

HEALTH EDUCATION

	COUNTY HEALTH DEPT.		
Type of Service	Health Officer	PH Nurse	Sanitarian
	Total	Total	Total
1. Meetings Attended, Spectator	3	13	2
2. Meetings Attended, Participant	4	22	3
3. Talks Made	2	18	2
4. Conferences	2	55	51
5. Programs Using Audio-Visual Aids		13	

SEMINOLE COUNTY HEALTH DEPARTMENT

Frank Leone, M. D., Director

Area of County: 352 square miles

Resident Population: 67,500

Number of Migrants: 11,000

Migrant Project Staff: 2 Public Health Nurses
1 Sanitarian
1 Clerk-Typist

SEMINOLE COUNTY

OUR SUMMARY TO DATE

The Seminole County Health Department has been in the migrant project for only three months. During this time we have been able to locate a facility in the heart of a large agricultural migrant area which is easily accessible to most workers. This is now being remodeled and equipped to be used as a clinic to render comprehensive medical services to these people.

The specific objectives of this program are to provide basic health services for the migrants, adapting these to the socio-cultural characteristics of this labor group, and to develop additional services as indicated. Some of the services to be given will include evening clinics with nurses and physicians in attendance as well as day clincis; furnishing of necessary drugs,- services for expectant mothers; seeing that the workers have adequate living conditions; proper diet and nutrition through our nutritionist; providing dental services, especially for children; seeing that they receive immunizations for various diseases; treating diseases already contracted; crippled children's services; vocational rehabilitation; etc.

We expect to present a program to provide health services adapted to the social characteristics of our migratory agricultural labor. Most of these people are Negro. Vegetable farming and citrus are the major industries. There are approximately 11,000 migrants in Seminole County.

Negro workers constitute 97% of this labor force. This group is poorly educated, many being illiterate. Many of the migrant households consist of six (6) or more persons. Living quarters are small and households are large. Their skills as well as their education are limited. Since many of these farm workers are residents of nowhere, very few can meet the residency requirements for any form of public assistance.

Complete physical examinations will be given with recorded abnormalities, etc.

Serologies and tests for venereal diseases will be done as well as Pap Smears for cancer detection in females.

Dental needs will be attended to and nutritional services used.

These migrants have frequent pregnancies and lack adequate prenatal care. They usually show bad oral hygiene, low hemoglobin and lack of nutrition. Most of them report late in the second trimester of pregnancy for prenatal care.

Children show nutritional anemias, pyodermas and ringworm of body and scalp. Group instruction is done with those attending prenatal clinics.

Dental defects are observed commonly in children and adults alike. Most frequently seen are caries, pyorrhea and abcesses.

There is a high incidence of intestinal parasitic infestation among agricultural migrants. Most of the children have worms at one time or another.

Health services to be offered to this group will include all of the basic public health services, namely; communicable disease control (immunizations), maternal and child health, chronic disease control, mental health services, environmental health services, health education, laboratory services, venereal disease, T.B., well-baby clinics, including family planning and cytology smears.

It is necessary that public health workers approach migrant workers in a manner that reflects sincere interest in him as an individual.

Negro Gray Ladies can act as liaison workers between public health workers and the migrants. Gray Ladies could talk to mothers and families concerning the necessity of health care, benefits of immunizations and even care for children while mothers and fathers are being examined.

In order to make health services more accessible to migrant farm workers, there must be flexibility in planning. The work patterns of migrants and the availability of health services must be compatible.

Effective public health work with farm migrants depends on offering a variety of health services during one visit to the health clinic. Schedules must consider the needs and conveniences of the migrant clients.

The migrant population is highly mobile, even within a given community, and case finding and continued follow-up is difficult. The migrant, whether white or Negro, is often suspicious of professional personnel.

His educational and economic opportunities have been sharply limited. His occupational opportunities, hence, are also limited. He must turn to agriculture, wherever it is, for a livelihood. His ideas about health are tied to his low educational status.

There are usually about five (5) females to every four (4) males. Many of these are young - under 25 years. The educational status is about 5½ years.

The matter of legal residence is especially important in the case of the migrant laborer since his right to any public services in Florida directly depends upon his status as a resident.

Many of the houses are substandard, do not meet sanitation standards and there are many violations. Most of them live under overcrowded conditions.

One of the important problems of migrant life is the caring for small children. The need for child-care facilities is great because of the mother's need to work. As a result, day care is often given by old women who are no longer able to work in the fields. Supervision in such cases is negligible and the quality of care poor. Where there are older children in the household, the responsibility for the small children is often placed upon them. In many cases, the older child is absent from school for days or even weeks becuase the parent, usually the mother, has to work and cannot pay day-care center fees.

As to their health, infant diarrhea and malnutrition is common. Usually they have no money to pay physicians and so do not see a doctor. In others, medical care is not considered important. Many of them have home remedies for almost anything.

The intelligent direction of social, economic and health services toward the migrant can be effective in meeting his needs.

While recruiting a migrant project staff, the health department is doing the following:

> Among the nurses' routine duties in the schools, she screens the children of migrants for vision, hearing, physical defects, emotional problems, etc. Those with defects are referred to the proper agencies for remedial attention. Much time is spent in securing assistance for these children since they are usually non-residents.
>
> Great stress is placed on educational programs, both in school and out, on communicable diseases, venereal diseases, personal hygiene, teenage marriages, unwed mothers, family living, etc. Personal counselling is also given by the nurse on these and other pertinent matters.
>
> Adult Negro education of basic health needs is necessary.
>
> The early years of childhood are the most critical.

The nurse spends a good part of her time in counselling adults, setting up educational programs with audio-visual aids, lectures (with the aid of outside organizations and community resources to assist her in this program). Physicians often assist with problems such as cancer, V.D. and tuberculosis. Self-help classes are held to instruct and motivate this group to seek medical attention.

Family planning class is held every month to counsel on child spacing, moral obligations to family and community, nutrition, personal hygiene, prevention and treatment of worms, the importance of immunizations and a question-and-answer period.

Home visits are made to instruct migrants regarding services rendered in clinics.

The Glaucoma Detection Clinic is offered for those 35 and over.

Pap Smears are performed to screen for cancer in females.

The nutritionist is often called on to give group counselling on diets where indicated.

An appropriate educational film is obtained for clinics such as family planning, maternity, immunization, well-baby and dental.

The clinics offered are: Immunization, Venereal Disease, Well-Baby, Maternity, Prenatal and Postpartum, Family Planning, Pap Smear, Glaucoma, Dental, Health Card, X-Ray, Nutrition, Mental Health, Sanitation Conference.

Many patients visited through our Home Nursing Service are migrants.

Out sanitation division has been doing the following:

We did not have the services of a full-time sanitarian for the Migrant Program this past year. However, the existing staff spent as much time as possible securing sanitation improvements in the areas where migrants live and work. When a full-time sanitarian is employed for this work, we can increase these activities and expand our planned programs.

The following activities have been perfomred in the migrant areas:

WATER: The most significant improvement made in water supplies is agreement by the City of Sanford to supply water to the Midway Section which is our largest migrant area. The existing wells in Midway do not meet chemical and bacteriological standards and this public water system will eliminate the hazard. The sanitarians were active in encouraging residents to sign up for connection to the City supply and worked with City officials regarding plans for taking in the area. Many Midway residents have not agreed to use City water. Much work is yet to be done since 100% connection is necessary for adequate protection of the people.

Approximately 25 open wells have been eliminated in other areas, closed systems installed and water piped into the homes. In the Altamonte area, the City water lines were extended outside the City Limits to serve a section where migrants live. This will eliminate 75 private wells when all are connected to the system. The sanitarians are attempting to secure 100% connection in this area.

WASTES: Efforts are being made to interest the City of Sanford in providing public sewer lines to the Midway Section and a planned sewer system in Altamonte will be designed to serve migrant areas. The sanitarians spend considerable time working with public officials and landlords, pointing out the need for providing these permanent sanitary facilities.

Approximately 50 insanitary privies have been eliminated and replaced with flush toilets connected to an approved septic tank.

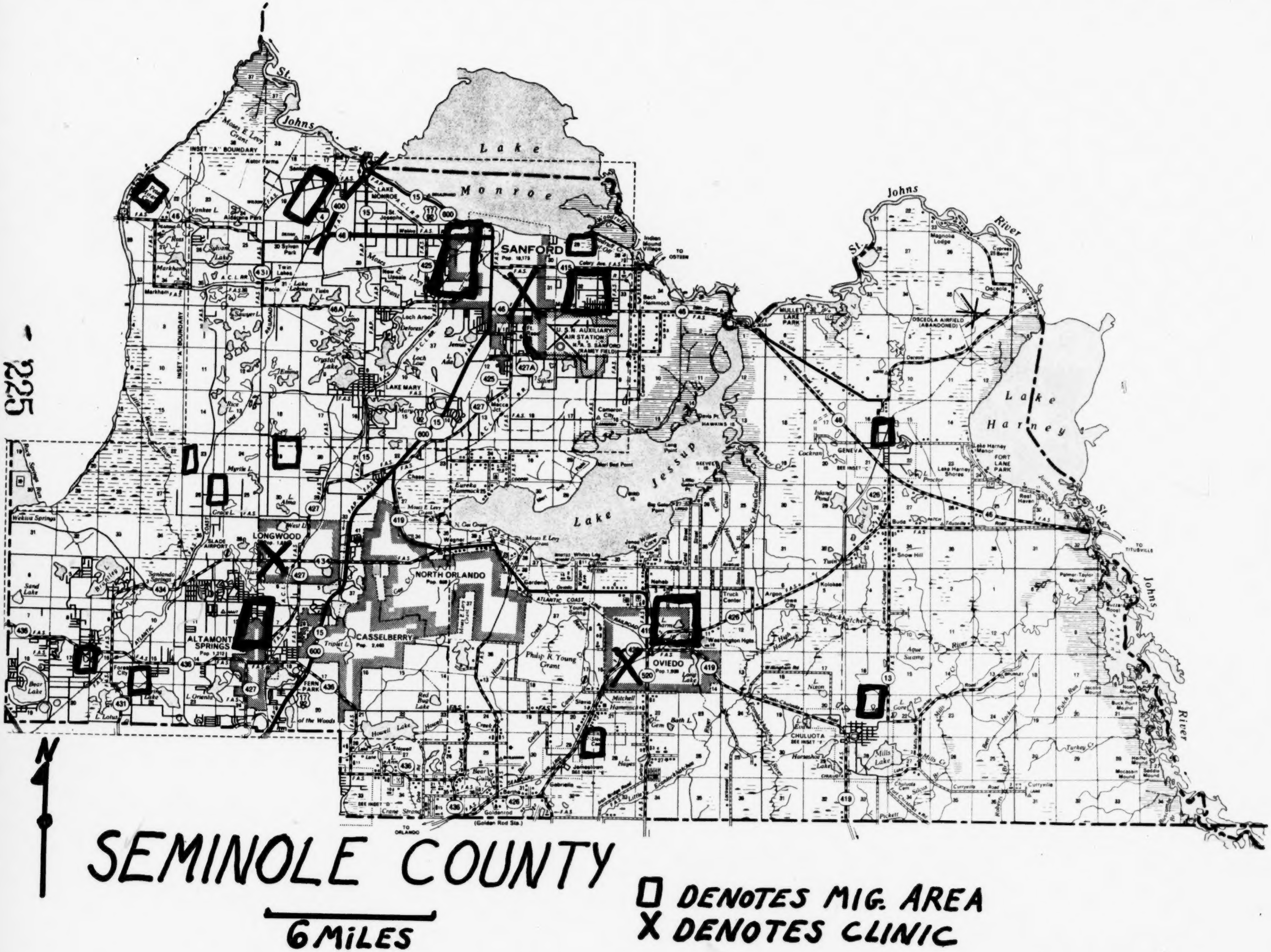
FOOD: Four (4) sanitation inspections of all eating and drinking establishments, grocery stores, meat markets and fruit stands were made during the past year in the migrant areas. Monthly visits should be made to these areas but with our existing staff we were unable to make additional visits.

HOUSING: Efforts are being made to secure a minimum housing code, through the legislature, for Seminole County. Approximately 100 private premises, rooming houses and apartment buildings were surveyed in migrant residential areas and follow-up visits made to secure improvements. All child care centers were inspected three (3) times and improvements secured where needed.

PUBLIC BUILDINGS: Routine inspection of the sanitary facilities are made and water samples collected. This includes packing houses, schools, churches, club houses and field locations where workers gather. Occupational health is discussed with farm owners, packing house owners and ministers. Progress has been made in improving sanitation, working conditions and the general environment of the laborers.

INSECT CONTROL: Sanitary landfills are operated in close proximity to all migrant areas and the sanitarians stress the importance of carrying all garbage and rubbish to these areas for proper disposal.

RABIES CONTROL: On January 1, 1966 the County put into effect an animal control law and approximately 100 stray dogs have been picked up from the Midway, Altamonte, Oviedo and Lake Monroe areas; all being migrant areas. Dogs running at large must have County tags. This improves our rabies control program considerably. The sanitation department is in charge of this activity.



SEMINOLE COUNTY

N
6 MILES
□ DENOTES MIG. AREA
X DENOTES CLINIC
Lake Monroe
St. Johns River
Lake Jessup
Lake Harney
SANFORD
LAKE MONROE
LAKE MARY
LONGWOOD
NORTH ORLANDO
CASSELBERRY
ALTAMONTE SPRINGS
FERN PARK
OVIEDO
GENEVA
CHULUOTA
MULLET LAKE PARK
OSCEOLA AIRFIELD (ABANDONED)
U.S.N. AUXILIARY AIR STATION
TO TITUSVILLE
TO ORLANDO
TO OSTEEN

ANNUAL REPORT

Nutrition Services

To

Florida State Migrant Health Project

February through April, 1966

Prior to February, 1966 the Nutrition Consultants of the Division of Nutrition, Florida State Board of Health provided limited services to the Migrant Health Project through their routine services as requested by the county health departments. This included inservice education to nursing staff, nutrition education programs in schools, distribution of nutrition education materials, institution consultation to hospitals and diet counseling to patients attending county health department maternity, child health and general medical clinics. Since February, 1966, the Nutrition Consultant assigned to the Southwest part of the state has assumed responsibility for coordinating and tabulating nutrition services to the counties participating in the statewide Migrant Health Project. The equivalent to the service of one full-time Nutrition Consultant has been provided to the Migrant Health Project by this Nutrition Coordinator and seven (7) Nutrition Consultants of the Division of Nutrition. The distribution of hours and service to counties by nutritionists is indicated in Monthly Effort Reports submitted to the Coordinator of the Migrant Health Project.

A Nutrition Trainee was assigned to work full-time in the Migrant Project in Collier County from February 15, 1966 to July 31, 1966. She has provided diet counseling to patients attending health department clinics (see Table I), conducted group classes for maternity patients, provided consultation and patient education programs for the child care centers and provided nutrition guidance through home visits to patients and families with chronic illnesses and other special dietary needs. She has also given information on nutrition in the school health program.

The Nutritionist assigned to Highlands, Hendry and Glades Counties has given limited diet counseling to migrant workers and conducted one food demonstration on the use of non-fat dry milk since milk, a highly nutritious, low cost food, is frequently not used in the diets of migrant families.

The Regional Nutrition Consultants have offered some inservice education programs and provided consultation to nursing staff working with the Migrant Health Projects in Seminole, Putnam, Flagler, Alachua and Manatee Counties. Priorities for nutrition services to migrant agricultural workers would appear to be maternity patients, infants and young children and those with chronic diseases requiring a therapeutic diet.

During the year the nutritionist working in Collier County participated in a panel on health services at a program for the Gulf Coast Health Conference which is composed of 13 counties. In this way she had an opportunity to describe services a nutritionist could provide in a migrant health project. The Nutrition Field Training Coordinator served as a Consultant to a conference on migrant health conducted by the New Jersey State Department of Health. The Nutrition Consultant assigned to the statewide Migrant Health Project participated as on observer consultant at a short course on nutrition education programs for low-income families at Syracuse University.

A statewide nutrition program plan, specific to meet the health needs in context with cultural, economic and social values of the migrant agricultural workers, is in the process of preparation. This plan would provide for reaching as many of the migrants using county health department services as possible. By inservice education programs for the various health disciplines serving migrants and preparation of simple, realistic educational materials, it is hoped that this population could be assisted to improve their food selection and preparation to overcome some of the health problems (such as nutritional anemia, weight problems, prematurity and complications of pregnancy failures in growth and development in children, etc.) which are attributable to poor nutrition.

Slides for use in nutrition education for two (2) migrant ethnic groups were made during the past year. Others are planned with the contents to include foods most often chosen by migrants. Scripts for use with the slides will be written and taped. It is planned to use the slides and tapes for group instruction of migrants in waiting rooms of health departments, in migrant clinics and also during meetings of migrants called by the nutritionists in camps, etc., to discuss child feeding, the maternity patient, etc.

Studies need to be made to further describe the nutrition needs and problems peculiar to the population of migrant agricultural workers and to better understand their cultural eating patterns.

TABLE I

DIET COUNSELING GIVEN IN COLLIER COUNTY CLINICS

Type of Diet Instruction	Number Counseled
Maternity	38
Weight Reduction	24
Child Health	14
Diabetes, etc.	10
Total	86

FUTURE PLANS

In the half year of this project period remaining, we expect to strive toward accomplishing those objectives not yet fully met. Naturally we will not "coast" on the objectives that seemingly have been achieved. So far this year there has been a noticeable increase in both the amount of service rendered and the number of persons served, especially in migrant clinics, over last year. This is borne out when one compares the county reports contained in the previous Annual Project Report with those in this current publication. The coming year (1967) should follow this upward serving.

Some plans have been formulated with the view in mind of escalating existing services offered to the target population. The following are a few examples of additional activities to be initiated during the year 1967:

Vision Screening: Tests made during the past three years on a total of 85,000 people in the counties of Broward, Pinellas, Polk and Volusia revealed that 15,587 or approximately 18% of the total number tested were found to have vision acuity of less than 20/40. Some of this group were migrants. We propose to "borrow" the services of a certified Orthoptist presently employed by the Bureau of Maternal and Child Health. This individual will travel around to the project counties and test the migrants for both vision acuity and eye muscle balance. She will also train personnel in the use of the Atlantic City Test Kit which will be used in this activity. We expect to conduct the tests on both adults and children in camps and in migrant clinics. This is not being carried on at present but we feel that it is a definite area of need. "Failures" will be referred to Optometrists or Ophthalmologists for complete eye examinations.

Diabetes Screening: We believe that diabetes casefinding should be instituted in the migrant clinics due to the lack of funds for adequate medical examinations from the private physicians in or near the communities in which migrants live or are employed. The prevalence of diagnosed diabetes among the lower income groups (below $4,000 annual income) was reported, in the publication "Diabetes Source Book," Public Health Service Publication No. 1168, May 1964, to be much higher than in females of over $4,000 annual income.

The most productive areas of casefinding have been found to be:

(1) Relatives of "known" diabetics - due to the hereditary factors involved in this disease;
(2) Persons over 35 years of age - as the older age groups are among the most productive areas of screening;
(3) Obese patients - because 85% of cases reported that they were obese prior to their being diagnosed as having diabetes;
(4) Mothers of large babies (weighing 10 pounds or over at time of birth) - in later years these women tend to develop frank diabetes;
(5) Pre-natal patients - the stresses of pregnancy frequently cause diabetes to "suddenly" appear. This can cause compli-

cations of pregnancy frequently debilitating to mother and/or child if undetected.

It is a fact that the mortality rate from diabetes is higher among non-whites than among whites. The majority of our migrants are non-white.

Some screening is now being done in a few migrant clinics but a great deal more should be done. We propose to "borrow" the services of the Program Coordinator for Diabetes Control of the Division of Chronic Diseases. This individual will go to project counties and instruct public health nurses in the clinics in the testing techniques for diabetes. Supplies for this purpose will be furnished 'gratis' by a drug concern that is interested in the screening results.

Dental Screening: There is a paucity of information concerning migrants' overall dental needs. Few surveys have been made and these were rather incomplete. We propose to "borrow" the services of a Dental Hygienist presently employed by the Bureau of Dental Health. This person will visit the Project counties and conduct a screening program on migrants, both adults and children. The screening will be carried on in migrant clinics and camps. Referrals of those needing dental work will be made to dentists serving in clinics or to private dentists on a fee-for-service basis. The screening program should give us a baseline to be used in better planning for a comprehensive dental program. At the present time all that we are sure of is that the migrant population in general has a definite need for both emergency and remedial denistry.

Tuberculosis Sputum Screening: The procedure presently used by counties to obtain sputum specimens from migrant T.B. suspects is to hand the migrant a sputum container and instruct him to go home, cough, expectorate into the container and send the container to the Florida State Board of Health Laboratory for examination. Everyone agrees that this procedure is unsatisfactory for a variety of obvious reasons (i.e., he does not understand, he does not send in the container, he contaminates the container by handling it, he has someone else expectorate in the container, etc). We propose to "borrow" the services of a Health Field Worker presently employed by the Division of Tuberculosis Control. This individual will go to the Project counties and instruct the public health nurses in the use of aerosol equipment for obtaining sputum specimens. By using the aerosol technique, specimens can be obtained in the migrant clinics from the suspects and the aforementioned drawbacks under the present system will be eliminated. We know that under the present unsatisfactory system, we are "missing out" on a substantial number of cases in the migrant population.

As some of the county reports indicate, there will be an increase in the number of migrant clinics operating during 1967. This will result in a consequent increase in the number of migrants treated and/or referred to specialists and other agencies. Certainly it will be beneficial to the migrants, and better health for these people is the primary goal of all Project personnel.

PROJECT OBJECTIVES FOR 1967

(1) To increase the amount and scope of health services offered to migrants, especially in the fields of medicine and denistry.

(2) To increase the health education activities offered to migrants.

(3) To increase the number of Migrant Health Service Referrals made and the number of Personal Health Records (PHS-3652) given.

(4) To increase the number of counties participating in the Health Service Referral Form System and in the Migrant Project.

(5) To increase the amount of information relating to the Migrant Project disseminated to the public.

Project Grant Number: MG-18C (66)

Project Title: A Project to Develop a Basic Statewide Program of Health Services for Migrant Farm Workers and Their Dependents in Florida

Period Covered: May 1, 1965 through April 30, 1966

SUMMARY

The second "action" year of the Florida "State" Migrant Health Project began in February, 1966 with fourteen (14) counties participating and extended through the calendar year. The period covered in this Annual Progress Report produced a definite increase in the amount of health services rendered, number of migrants contacted and activities performed by Project personnel.

Fewer foreign workers were employed in Florida this year than last. The number of Anglo workers increased during the past year while the number of Negro workers decreased. Some areas experienced vegetable harvest periods later than usual due to cold weather conditions. This, coupled with an increased spring citrus harvest, extended the stay of some migrants in Florida. Mechanization involving bean picking and celery cutting increased due to an inadequate labor supply.

A review of 541 Migrant Health Service Referrals which was completed during the early part of 1966 indicated that direct service was extended to 52.7% of the cases. Five (5) categories of service accounted for 81% of the requests. Negro patients were the majority of the total number served with 64.4%. Females predominated the group served with a percentage of 64.4. An evaluation of the System presently in progress reveals that 850 referrals have been returned to Florida. Ten (10) states now have their own indexes. Twenty-two (22) Florida counties are presently actively participating in the System.

Twelve (12) objectives are slated to be met by Project personnel before the year ends. Actually one (1) of these is being partially met through the use of VISTA workers as liaison workers due to lack of funds to employ migrants in this capacity as originally intended. It appears at this point in the Project period that the objectives will probably be substantially met by the advent of the new year.

As in previous years, some resistance was encountered by sanitarians from growers who were reluctant to comply with certain regulations concerned with migrant housing. Indifference on the part of some public officials also hindered progress to some extent in improving living conditions for migrants. On the whole, however, there was reported to be an increase in cooperation by growers and migrants alike. Some unsatisfactory housing was condemned and replaced by new structures.

Nursing services increased as did the number of migrant clinics, especially those held during evening hours. The census of migrant clinic patients rose gradually to an all-time high before the exodus from Florida began. An appreciable number of migrants received dental care under Project

auspices, some for the first time in their lives. Hospitals continued to lose money, as did many physicians, due to migrant unpaid bills.

The nutrition program initiated this year specifically for migrants functioned satisfactorily but needs to be intensified. Many of the migrants, especially prenatal patients, received counselling from the nutritionists. Slides were developed to be used in nutrition education and more are planned.

Plans for the future call for continued progress toward meeting the objectives set for this year. During the coming year additional services are expected to be offered the migrant population including screening for diabetes, vision, tuberculosis and dental defects. Several counties are planning on increasing the number of migrant clinics held and a couple of counties plan on starting migrant clinics for the first time.

Project objectives for 1967 includes increasing health services, health education activities, health service referrals, number of Project counties and amount of information relating to the Project. The number of objectives is small but the potential is great in terms of benefit to the migrant worker and his family.